



## DOCTOR OF HEALTH (DHEALTH)

### **Making Sense of Street Chaos**

### **An Ethnographic Exploration of the Health Service Usage of Homeless People in Dublin**

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# **Making Sense of Street Chaos**

## **An Ethnographic Exploration of the Health Service Utilization of Homeless People in Dublin**

**Dr Austin O Carroll MICGP**

A thesis submitted for the degree of Professional Doctorate in Health

University of Bath

Department of Health

May 2015

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**Title of the Project:****Making Sense of Street Chaos: An Ethnographic Exploration of the Health Service Utilization of Homeless People in Dublin****Abstract**

The aim of this study was to explore the Health Service Utilization (HSU) of homeless people in Dublin. In particular, it sought to identify a critical realist explanatory model for why the HSU of homeless people differs from that of the general population. Critical realist (CR) ethnography was used as the research methodology and was supplemented with forty-seven semi-structured interviews and two focus groups.

The HSU of homeless participants in Dublin is described. When compared to the domiciled population, homeless people were found to have a tendency to present late on in their illness, to have higher utilization of primary care services and lower utilization of secondary care services and to avoid psychiatric services.

The factors that influenced participants HSU tendency are identified as external or internal influences on HSU. External factors are described as physical, administrative or attitudinal barriers or deterrents; or external promoters of health service usage. Internalised inhibitors and promoters are illustrated as either cognitions or emotions that are developed in reaction to external circumstances and which either negatively or positively impact on health service usage. Interactions between health professionals and participants that resulted in exclusion (by the health professional or self-exclusion) are described as Conversations of Exclusion. A critical realist model was outlined that offers an explanation for why homeless people's HSU differs from that of the general population in Dublin. This model included a description of the generative mechanisms identified as producing the HSU tendencies in the study population.

The implications of this new model are discussed in the light of the literature and previous models that seek to explain the HSU of homeless people.

## **Abbreviations**

**CapP:** Capuchin Food Hall Participant.  
**CR:** Critical Realist  
**ED:** Emergency Department.  
**EDP:** Emergency Department Participant  
**FG1P:** Focus Group 1 Participant  
**FG2P:** Focus Group 2 Participant  
**HSU:** Health Service Utilization.  
**HSE:** Health Service Executive.  
**McVP:** McVerry Trust Participant.  
**OPD:** Hospital Outpatients.  
**OW:** Outreach Worker  
**RST:** Rough Sleeper Team  
**RSTP:** Rough Sleeper Team Participant.

## **Glossary**

**Actual Level:** See Critical Realism.

**Anderson's Behavioural model:** This three stage model was devised to explain why families differed in the way they use health services. Firstly, there are factors that predispose to families using health services. Secondly, there are conditions which make it favourable or unfavourable for families to use health services. Thirdly, families have to perceive a need for health services and respond to that need. The result of these is usage of the health service. Usage was subsequently added as a fourth component of the model as positive experiences of usage promote further usage.(1)

**Competing Priorities:** Homelessness often causes people to alter their prioritization of need whereby seeking healthcare drops down their priority list. These other needs (e.g. finding housing or employment, keeping welfare appointments, and finding child care) are perceived as being of a higher priority to seeking healthcare.(2)

**Confirmability:** Confirmability refers to how closely the results derive from the actual experiences of the participants and/or of the events that took place rather than the preferences, beliefs and bias of the researcher. Supporting accounts from the literature and/or from differing sources in the research field can improve confirmability.(3, 4) Miles & Huberman suggest confirmability is best achieved by the researcher declaring their prior preferences.(5)

**Credibility:** Credibility in Qualitative Research refers to how faithful is the description and interpretation of the participants' account/experiences to their actual account or experience. A credible account would be recognised and verified by the participant. Merriam suggests credibility refers to the question of "how congruent are the findings with reality?" (4, 6)

**Critical Realism:** Critical realism is a philosophical position that was first posited by Roy Bhaskar. Critical realists recognise the fallibility of scientific observations and the constructed nature of social concepts including scientific practice. However, they do not accept the radical form relativism that rejects the concept of a discoverable reality that is

not contingent on human perception. Critical realists argue that reality is stratified into the empirical level (i.e. the level of observable experiences); the actual level (i.e. the level that events take place that may or may not be observed); and the generative level i.e. the level at which natural and social structures and mechanisms generate the events that take place in the actual level. (7)

**Dependability:** Dependability refers to how likely it would be to discover the same findings if one repeated the research study. This is a problematic concept for qualitative researchers due to the changing nature of the social research phenomena. Overlapping methods (e.g. focus groups and semi-structured interviews) have been suggested as ways to improve dependability.(3, 4)

**Discrimination:** Discrimination involves making any distinction, exclusion, restriction or preference that: *'has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.'* (8)

**Dual Diagnosis:** Dual diagnosis refers to a person suffering from both a mental health illness and a substance misuse disorder.(9)

**Empirical Level:** See Critical Realism.

**Ethnography:** *"Ethnography is iterative-inductive research (that evolves in design through the study), drawing on a family of methods, involving direct and sustained contact with human agents, within the context of their daily lives (and cultures), watching what happens, listening to what is said, asking questions, and producing a richly written account that respects the irreducibility of human experience, that acknowledges the role of theory, as well as the researcher's own role, and that views humans as part object/part subject."*(9)

**Fallibilism:** Fallibilism is a philosophical position that posits that absolute certainty about knowledge is impossible as all claims to knowledge could be mistaken. Unlike scepticism. fallibilism does not suggest we reject our knowledge base but rather that in our use and interpretation of that knowledge we need to be aware of the potential for that knowledge to be false.

**Falsifiability:** Falsifiability (also known as refutability) refers to the logical possibility that any assertion could be demonstrated to be untrue or false through experimentation. It is not saying the assertion is false, rather that if it is false, this falsity could be demonstrated through experimentation.(10)

**Generative structures/mechanisms:** Generative structures or mechanisms generate the events that take place at the actual level which may or may not be observed at the empirical level (see critical realism). Generative structures or mechanisms can exist in the natural or social worlds. Generative structures or mechanisms produce tendencies for events to take place at the actual level i.e. it does not necessarily mean the event will take place. Critical realists believe that generative structures and mechanism cannot be observed but their existence can be identified through their effects at the actual and empiric levels.(7)

**Health Belief Model:** The Health Belief Model is a psychological model designed by Hochbaum, Rosenstock & Kegels to predict and explain health behaviours. It posits that peoples health behaviours can be explained by four variable i.e. perceived susceptibility to an illness; perceived severity of an illness; perceived benefits of a particular course of action to improve their health; and perceived barriers to taking those actions to improve health.(12)

**Health service utilization:** Health service utilization has been defined as the outcome of the interaction between health professionals and patients.(13)

**Naive questioner / acceptable incompetent:** The ‘naive questioner’ is an approach that ethnographers adopt when interviewing clients on the field. By asking seemingly naive questions, respondents make fewer presumptions that the questioner has implied knowledge and are more likely to give a fuller explanation. It also enables the researcher to explore unexpressed presumptions or beliefs that affect their behaviours and expressed beliefs.(14)

**Reflexivity:** *‘Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape*

*everything about inquiry; and, in between researcher and participant to the social interaction they share.’(15)*

**Retroduction:** Retroduction was suggested by Roy Bhaskar as a methodological approach in critical realist research (see critical realism) for identifying generative structures and mechanisms via observations at the empirical level. Retroduction involves creatively postulating as to possible generative structures or mechanisms that could generate the empirical observations of the researcher. The researcher then seeks to find which of those hypothetical structures or mechanisms produces a ‘best fit’ explanation for the range of empirical observations. (7)

**Specialized health services for homeless people:** Specialized health services for homeless people are services that are created specifically for homeless people. They are designed to suit the lifestyle of homeless people. Thus, they are often delivered at sites where homeless people frequent such as food halls; drop in services; hostels; or as part of an outreach service.

**Stigma:** Stigma refers to an attribute that is deeply discrediting socially This discrediting needs to be understood in terms of social relationships as an attribute that might be discrediting in one social relationship may be perceived as unusual in another.(16)

**Supported temporary accommodation:** Supported temporary accommodation is hostel accommodation for homeless people where they are guaranteed to have the accommodation for a minimum of 6 months.

**Tendencies:** See Generative Structures.

**Transference / Counter-transference:** Transference occurs when a person unconsciously and inappropriately, transfers feelings and attitudes from a person or situation in the past lives on to a person or situation whom they have a relationship in the present. Countertransference is the emotional and attitudinal response that is elicited in the recipient by another person’s transference process.(17)

**Transferability:** **Transferability** refers to how applicable the research results would have in other contexts or environments. Lincoln & Guba suggest that the researcher needs to provide a rich enough description of the research field and context to enable the reader to make a decision if the results could be applied to their situation.(4, 6)



## CHAPTER 1: INTRODUCTION

### **Introduction:**

I have worked in inner city Dublin as a youth worker from 1980 to 1989 and as a GP since 1997. My practice is located in an area of deprivation which contains many homeless hostels. Since 2004 I have developed 7 primary care services tailored for homeless people in hostels and food-halls and I also was involved in the development of 3 other such services. In 2007 I set up Safetynet, a voluntary agency that helps develop and support primary care services for homeless people and immigrant communities in Dublin, Cork and Limerick.

It has been apparent to me that homeless people's Health Service Utilization (HSU) is very different to that of the general population. It has seemed to me that the different HSU resulted in poorer access to healthcare resulting in patients presenting late on in their illness course and very often extremely unwell or moribund. It has also been apparent that in seeking to access healthcare my homeless clients faced many barriers to access both primary and secondary care. I often have had to advocate on their behalf to obtain access to such services as they had found the barriers insurmountable. Lastly, I have always been aware that the behaviours of homeless people have contributed to their poor health and their difficulty accessing healthcare. However, I have never believed these behaviours resulted from a character trait but rather a result of the effects of being homeless.

Most of my work has been involved in developing services. I recognized that research skills were hugely beneficial in the creation and development of services both for identifying how best services could meet health needs and also in evaluating whether the services were achieving their objectives.

These were the influences on my decision to seek to understand the HSU of homeless people. I chose ethnography for a number of reasons pertinent to the research aims (outlined in Chapter 4). However, I also had a desire to step out of the doctor/expert/service provider role. I felt that ethnography offered the opportunity to 'get down and dirty' and actually gain an understanding of the world in which homeless people which was denied to me in my doctor garb. I was drawn to this not only for

research purposes, but also to challenge my understanding of my role as a doctor.

### **The Research Question**

Using an ethnographic approach allowed me to start with broad research aims and objectives that could become more focused as I immersed myself in the field. When exploring the possible research approaches I was drawn to critical realism as its central tenets resonated with my own personal philosophy and also it allowed me to explore the constructed nature of homelessness while recognizing the harsh reality encompassed by the homeless lifestyle. My research question emerged within the context of these factors from my reading of the literature.

The aim of this research is to gain an insight into homeless people's health service usage behaviour in Dublin. The research questions directing this study are: What are the generative mechanisms that cause homeless people to consult differently from the domiciled population? When and why do homeless people decide to consult? Why do they decide to not consult when ill? How do they decide who to consult? How do past experiences of consulting health services influence their present behaviour?

As a result of this research it is intended to suggest policies, strategies and behaviours that will promote best practice in health service provision to homeless people and to produce a guidance manual on best practice in health service provision for homeless people.

### **Structure of the Thesis**

This thesis comprises six chapters:

- Chapter One serves as an introduction to the thesis outlining the reasons for choosing this research area, detailing the research aims and objectives and outlining a summary of each chapter.
- Chapter Two reviews the literature on the nature of homelessness and summarizes the evidence on the physical and mental illnesses experienced by homeless people. It further explores the substance misuse patterns in the homeless population as described in the literature.
- Chapter Three explores the literature to see how homeless people use health services and how this differs from how the general population uses those

same services. It goes on to review and compare the factors identified in the literature that affect the HSU of the general and homeless populations. Lastly, it critically reviews the explanatory models and theories for the HSU of homeless populations.

- Chapter Four outlines the design chosen to enact this research. It seeks to explain the rationale for choosing this particular methodology. The process of entering the research field; managing relationships in the field and exiting are described. Data collection and analysis is described. The ethical issues are outlined. Finally, the limitations of the research design and process are discussed.
- Chapter Five outlines research findings that relate to the HSU patterns of participants in this research and compares these patterns to the international literature.
- Chapter Six outlines a number of generative mechanisms that were identified as producing the HSU tendencies of the homeless participants. It identifies Irish and international research that supports such generative mechanisms.
- Chapter Seven outlines a proposed Critical Realist Explanatory Model that seeks to explain why the HSU behaviour of homeless participants in this research differed from that of the general population.
- Chapter Eight discusses these findings in the context of the literature. The findings that are new to the literature are outlined and discussed. The proposed critical realist model is then compared to other explanatory models for homeless people's HSU that already exist in the literature. The implications of this new model for the policy of providing tailored services for homeless people are outlined. Finally, how the duality of structure and agency is expressed in the model is also discussed.
- Chapter Nine starts with a summary of the research and its findings. It outlines the implications of these findings for policy and practice. Recommendations for further research are made. Lastly, the limitations of the research are outlined.
- The appendices include suggestions for how ethnographers can remain safe when working in the field.

I am a 'late starter' when it comes to research. I had developed the presumption that being an activist I had not the necessary reflective ability to conduct research. As such, having been encouraged by colleagues to engage in research, I have found the journey revelatory. Firstly, I found how enjoyable I found research once it was relevant to my work on the ground. Secondly, it revealed to me a personal reflective capacity that I had been tapping into, but had not identified as reflectivity. Research has opened up avenues for exploring the factors that affect the health of my patients; improving the services I already am involved in providing; helping identify where new services could improve health; and lastly, it has enabled me to cultivate and develop my burgeoning reflectivity.

## **CHAPTER TWO: HOMELESSNESS AND THE HEALTH OF HOMELESS PEOPLE.**

The number of homeless people in Ireland fell during the economic boom, but rose in the subsequent recession (2,900 in 1999[18], 2,920 in 2002[19], 2,280 in 2005[20], 2,366 in 2008[21] and 3,808 in 2012[22]). The vast majority of homeless people are located in Dublin.[22] Homeless populations internationally and in Ireland, tend to be predominantly male though there is an increasing representation of women.[23] The shift from predominant alcohol misuse to drug misuse amongst homeless populations has been put forward to explain this changing demographic as there are a higher proportion of female drug users than drinkers.[23]

It has been estimated that 23% of the homeless population in Ireland have been homeless for more than one year.[23] While a relatively small group within the overall population of homeless persons, it has been noted that their consumption of health and social services is disproportionately far greater than other homeless people.[23]

In this literature review, I firstly explore the constructed nature of homelessness. Secondly, I outline the health profile (in terms of mortality, physical and mental morbidity) and the substance misuse patterns of international and Irish homeless populations.

### **Search Strategy**

I moved from sensitive to specific searches using Pubmed, Embase, Web-of-Knowledge, PsycINFO, Social Care Online, SIGLE and Google. I looked up Consulting Behaviour (MESH) and motivation (MESH) individually. I combined homeless (both MESH and non MeSH – limited to Title/Abstract) and health, Health Services, Emergency Department, Primary Care, Motivation, Consulting behaviour, (MeSH) and competing priorities (non MeSH – limited to Title/Abstract). I checked EThOS for relevant theses. I checked through references and subsequent citing articles. Lastly, I e-mailed colleagues working in research and with homeless people and sought further references.

### **What is Homelessness?**

There is no accepted, uncontested, international definition for homelessness. Homelessness can either be interpreted narrowly as applying solely to the ‘literal homeless’ or broadly

where homelessness can be defined anywhere along a spectrum of housing tenure insecurity. (Table 2.1).

<b>Table 2.1 : Theoretical Domains of Homelessness.[24]</b>			
<b>Conceptual Category</b>	<b>Physical Domain</b>	<b>Legal Domain</b>	<b>Social Domain</b>
<b>Rooflessness</b>	No dwelling (roof)	No legal title to a space for exclusive possession	<i>No private and safe personal space for social relations</i>
<b>Houselessness</b>	Has a place to live, fit for habitation	No legal title to a space for exclusive possession	<i>No private and safe personal space for social relations</i>
<b>Insecure and Inadequate housing</b>	Has a place to live (not secure and unfit for habitation)	No security of tenure	<i>Has space for social relations</i>
<b>Inadequate housing and social isolation within a legally occupied dwelling</b>	Inadequate dwelling (unfit for habitation)	Has legal title and/or security of tenure	<i>No private and safe personal space for social relations</i>
<b>Inadequate housing (secure tenure)</b>	Inadequate dwelling (dwelling unfit for habitation)	Has legal title and/or security of tenure	<i>Has space for social relations</i>
<b>Insecure housing (adequate housing)</b>	Has a place to live	No security of tenure	<i>Has space for social relations</i>
<b>Social isolation within a secure and adequate context</b>	Has a place to live	Has legal title and/or security of tenure	<i>No private and safe personal space for social relations</i>

This study concentrated in literal homelessness (see methodology).

It is important when reviewing the literature on homelessness to recognise that the nature of homelessness differs in the US and Europe. There are several reasons for this, many of which are rooted in differing social protection and housing policies with the US having less welfare safety net provisions and social housing provision than their European counterparts. Thus, homelessness in the US corresponds to literal homelessness with particularly large numbers of rough sleepers.[25].

Jacob et al argue that the definition of homelessness is a socially constructed entity.[26] It has been argued that this construction has the potential to result in stereotyping of those labelled homeless and further, of blaming the labelled person for their predicament.[27, 28] It further creates an artificial division between homelessness and poverty. The breadth offered by the varying definitions and the statistics demonstrating the high rate of crossover between 'homelessness' and domiciled poverty reflect this artificiality.[30]

However, even if the label is socially constructed, there is a reality to the experience of being 'homeless' which has been described in the literature. This reality is characterised by the challenges of daily survival; spending excessive energy seeking food and shelter; begging; unemployment; lack of income; poor hygiene; difficulty fulfilling tasks of everyday living; difficulty coping with stress; addiction to drugs or alcohol; exposure to violence; involvement with crime; and poor mental and physical health.[31-34] Davis contended that so called 'homeless ways of life' are in reality survival strategies.[31]

The pathway to homelessness is not necessarily a single step. It can result from a series of transitions such as running away from family, entering foster homes, entering child punishment institutions and ending up on the street.[34] A large number of other factors have been identified as contributing to homelessness. These include poverty[35]; personal issues (mental health problems, early psychological trauma and entering child punishment institutions)[32, 36]; familial issues (early psychological trauma, familial conflict /breakdown, familial violence, parental substance misuse and physical, sexual or emotional abuse and a history of being in foster-care)[32, 37-41]; social issues (poor social support/networks)[42]; structural issues (lack of affordable housing, poverty, unemployment and substance misuse)[34, 38, 43]; crime[44]; and gender based issues (sexual assault, domestic violence and family breakdown which disproportionately affects

women's income)[45-47]. These same factors also contribute to maintaining people in homelessness.[23]

Social constructions of homeless and stigma mutually re-enforce each other. Homeless persons can be negatively perceived by the general population, and this negative stereotyping is often reinforced by the media.[48] Homeless people in the 19<sup>th</sup> century were perceived as work-shy and lazy, so the Poor Law workhouses were set up to discourage dependency on the state.[49] Research carried out by Hocking & Lawrence (2000) concluded that the stereotype most attributed to homeless people was that of being 'male, lazy, morally bankrupt and potentially dangerous.....a character flaw rather than a product of socio-economic circumstances.[50]

### **Physical Health and Homelessness.**

Homeless people's mortality rates are 3.5 – 40 times that of the general adult population (with rough sleepers having the highest rate).[42] The physical morbidity profile for the homeless population is worse than the general population both for conditions common within the general population[42] as well as conditions more rarely found such as HIV, hepatitis, tuberculosis etc.[42] The range of conditions that affect homeless people internationally and in Ireland can be seen in Tables 2.2 & 2.3. It is recognised that homelessness causes poor health and poor health causes homelessness.[47]

Certain subgroups within the homeless population have been identified as having particular health issues.

- Older homeless people have poorer health outcomes. They are three times more likely to have a chronic medical condition and have higher age-specific mortality rates than the general population.[51] The health of homeless young people is put at particular risk from drug use, victimization, sexual risky behaviour, drifting into prostitution and experiencing poor living conditions.[52] As predicted by Tudor Hart's law they have less access to health care.[53]
- Homeless women are particularly vulnerable with high rates of mental illness, histories of physical and sexual abuse, higher risk of drug abuse and poor social networks.[29] They also have high rates of pregnancy.[54]



<b>Table 2.2 Physical Health Status of Homeless People in the International Literature.<sup>1</sup></b>		
<b>Addiction:</b>	<b>Drug</b>	<i>Heroin</i> [42]
		<i>Cocaine</i> [55]
		<i>Benzodiazepines</i> [55]
	<b>Alcohol</b>	<i>Alcohol Dependence</i> . [57]
<b>Addiction Related Conditions</b>	<b>Tobacco</b>	<i>Tobacco Addiction</i> [58-60]
	<b>Gambling</b>	<i>Gambling Addiction</i> [61]
	<b>Drugs</b>	<i>Death related to overdose</i> [62]
		<i>Blood Borne Infections:</i> <ul style="list-style-type: none"> <li>• <i>HIV</i>[55, 63]</li> <li>• <i>Hepatitis B and C</i>[43]</li> </ul>
		<i>Skin Infections, Ulcers Abscesses and Cellulites</i> . [23]
	<b>Alcohol</b>	<i>Wernickes Encephalopathy</i> [62]
		<i>Korsakoffs Psychosis</i> [62]
		<i>Cerebellar Degeneration</i> [62]
		<i>Peripheral Neuropathy</i> [62]
		<i>Cardiomyopathy</i> [62]
		<i>Peptic Ulceration</i> [63]
		<i>Oesophagitis</i> [63]
		<i>Pancreatitis</i> [62]
		<i>Alcoholic Hepatitis</i> [57]
		<i>Alcoholic Cirrhosis</i> [62]
		<i>Oesophageal Varices</i> [62]
		<i>Carcinoma of Oropharynx and Oesophagus</i> [62]
		<i>Thiamine Deficiency</i> [62]
		<i>Epilepsy</i> [64]
	<b>Drugs or / and Alcohol</b>	<i>Depression / Anxiety and Suicide</i> [62]
		<i>Psychosocial complications e.g. family breakdown, unemployment etc.</i> [62, 64]
	<b>Cigarette Smoking</b>	<i>Respiratory Disease (COPD, Cancer of the Lung)</i> . [58,59, 64]
		<i>Cardiac Disease</i> [29]
<b>Familial Backgrounds</b>	<b>History of Abuse</b>	<i>Physical Abuse</i> [28, 47]
		<i>Sexual Abuse</i> [28, 47]
<b>Nature of Homelessness</b>	<b>Lack of Safety</b>	<i>Accidental Trauma</i> . [52]
		<i>Assault/Violence/Non accidental Injury</i> . [29]
		<i>Sexual assault and rape</i> . [52]
	<b>Walking related Trauma</b>	<i>Foot Problems</i> . [64]
	<b>Unhygienic Conditions.</b>	<i>Dental Problems</i> . [64]
		<i>Skin Infestations (Scabies, Lice)</i> [62]
		<i>Rare Infections (Typhus, Trench Fever, Relapsing Fever)</i> [62]
		<i>Pneumonia</i> [62]
	<b>Crowding, Exposure to Elements &amp; Poor Nutrition.</b>	<i>Tuberculosis (esp. in those affected by HIV)</i> [64]
		<i>Skin Infections (Cutaneous Diphtheria, Impetigo, Viral Warts, Fungal)</i> [62]
		<i>Skin Ulcers</i> [23]
		<i>Obesity</i> [62]
	<b>Difficulty Maintaining Nutrition</b>	<i>Poor Diabetic Control</i> [64]
	<b>Risky sexual practices / Survival Sex</b>	<i>Sexually Transmitted Diseases</i> . [64]
	<b>Physical effects of Homelessness</b>	<i>Musculoskeletal problems</i> [64]
<b>Unexplained Excess Morbidity</b>		<i>Cancer</i> [65]
		<i>Epilepsy</i> [64]
		<i>Hypertension</i> [63, 64]

<sup>1</sup> Of note most of these studies are self-reported health conditions.

<b>Table 2.3: Physical Health Status of Homeless People in the Irish Literature (expressed in percentages of respondents who self reported having being diagnosed with the health condition)</b>					
<b>Category of Illness</b>		<b>Feeney et al 2001[66] (Self reported)</b>	<b>Condon et al 2001[67] (Self reported and examination)</b>	<b>O'Carroll &amp; O'Reilly 2008[23] (Self reported)</b>	
Physical Symptoms	All	54%			
	Eye and Ear Complaints	24%			
	Headache	22%			
	Problems with bones and joints	19%			
	Skin Problems	18%		14%	
	Foot Problems	15%		21%	
Dental Health Problems	All	50%		53%	
Chronic Physical Health Problems	All	56%			
	Asthma	13%		23%	
	Bronchitis/Emphysema	13%	20%	16%	
	Peptic Ulcer Disease	10%	18.5%	11%	
	High Blood Pressure	10%	9%	14%	
	Heart Disease	7%			
	Rheumatic Disease	4%	13%	14%	
	Epilepsy	4%	3%	8%	
	Urinary Tract	4%			
	Gastro-intestinal tract	4%			
	Diabetes	2%	2%	1%	
	Tuberculosis	2%		3%	
	HIV+	1%	1%	6%	
	Hepatitis C	5%	7%	36%	
	Hepatitis B		1%	5%	
Self Rated Health	Good to excellent			46%	
	Fair to Poor			54%	
	Health Worse than 1 year ago			37%	
	Physical Health limited Activities Daily Living (ADL)			44%	
	Mental Health limited ADL			47%	
Of note these studies were taken from at different dates during the economic boom in Dublin when the homeless population had a changing profile from predominantly alcohol addicted to drug addicted which may explain the variation in results.[23]					

### **Mental Health and Homelessness.**

It is well recognized that homeless people have much higher levels of mental ill-health than the general population.[69-83] Suicide rates are also high among homeless people. Particular mental health problems that are commonly found in the homeless population include schizophrenia, depression, bipolar disorder, major depression and suicidal ideation.[60] Irish studies have replicated this trend with the prevalence of clinical depression among the homeless population estimated between 35% and 51%, anxiety between 32% and 42% and schizophrenia 11%.[66, 67, 85, 86]

Both the social backgrounds and the fact of becoming homeless have been recognized as contributing to the high rates of mental illness.[60] Homeless women are particularly vulnerable to mental illness.[60] Homeless persons with mental health problems have been found to be homeless for longer, have poor contact with their family and friends, have greater barriers to employment; to be in poor health, have a higher likelihood of being hospitalised for poor physical health and more likely to be involved in crime.[87]

<b>Table 2.4 Mental Health Conditions common in the Homeless Population in International Literature.</b>	
<b>Mental Illness</b>	Depression[60]
	Anxiety[56, 63, 88]
	Schizophrenia.[60]
	Suicide[89]

<b>Table 2.5 Mental Health Status of Homeless People Irish Literature</b>					
<b>Category of Illness</b>		<b>Feeney et al 2001[66]</b>	<b>Condon et al 2001[67]</b>	<b>O'Carroll &amp; O'Reilly 2008[23]</b>	
Mental Health Problems	All	64%			
	Depression	52%	20%	51%	
	Anxiety	50%		42%	
	Schizophrenia			11%	
	Other Psychiatric Problems	4%			

Several studies have shown that homeless people with mental health problems have difficulty accessing mental healthcare.[60] Drury (2003) described a cultural pattern of mutual avoidance between homeless mentally-ill individuals and caregivers.[90]

### **Substance Misuse and Homelessness.**

Alcohol and drug addiction are pervasive in the homeless population.[23] Over the last twenty years, internationally, and in Ireland, the risk behaviour pattern of the homeless population has shifted from alcohol abuse to drug addiction. This changing risk-behaviour profile has brought with it an upsurge in associated health problems, in particular blood borne infectious diseases.[23]

Many people enter homelessness due to alcohol abuse, often as a result of a pattern of binge drinking that leads to them losing their employment and then their home.[91] Homeless people who abuse alcohol suffer from poorer physical health. They are 4-7 times more likely to have liver dysfunction; twice as likely to suffer serious trauma; 2-3 times more likely to have a neurological disorder (most commonly being epilepsy); twice as

likely to have nutritional deficiency; 1.5 times as likely to have hypertension, chronic obstructive pulmonary disease, peptic ulceration, nerve damage and arterial disease.[92]

In Dublin, the prevalence of drug misuse has been estimated through surveys to be between 29-70% for life time usage of illegal drugs (including cannabis) with 23-30% having problem drug-use.[23, 86] Injecting drug use and polydrug use, especially the use of cocaine and heroin, are becoming more prevalent.[93-95] Drug misuse is associated with poorer access to healthcare. [96-98]

Drug use contributes to homelessness and, in turn, makes it more difficult to exit homelessness.[99-102] The reasons attributed to young homeless persons' first involvement in drug use include a history of physical or sexual abuse, parental drug or alcohol misuse, low self esteem and the fact of being homeless in the first place.[92 103-104]

Medical treatment for drug misuse is either through the provision of methadone maintenance or drug detoxification programmes. Homeless people find difficulties accessing such services.[105-107] In 2005, despite 36% of Dublin's homeless population being intravenous heroin-users, only 18% were on methadone and, of these, 28% were not prescribed it.[86] Patients on methadone face significant levels of discrimination when seeking primary-care providers.[108] Homeless drug users who have detoxed find the treatment ineffective due to the lack of aftercare and residential support programmes.[109] Having a supportive parent and family makes it more likely for a young person to recover from drug use.[110]

Dual diagnosis (the concurrence of mental illness and substance misuse) affects a significant proportion of the homeless population with estimates of prevalence ranging from 2 to 34%. Clients with dual diagnoses are generally homeless for longer; report more involvement with the criminal justice system; have a lower subjective quality of life; and have more difficulty accessing healthcare than their non-dually diagnosed counterparts. [111-113]

In summary, homeless people have poor physical and mental health profiles when compared to the domiciled population. Homeless population also have high rates of

substance misuse including alcohol and illegal drugs. With this poor health profile it is important to understand homeless people's utilization of health services.

## **CHAPTER THREE: THE HEALTH SERVICE UTILIZATION OF HOMELESS PEOPLE.**

This chapter reviews the literature that describes the Health Service Utilization (HSU) of homeless people i.e. how homeless people use primary and secondary care services. A comparison of HSU of the general and homeless populations is conducted followed by a review of explanatory models for homeless people's HSU.

### **How do Homeless Persons Use Health Services?**

It is recognized in the literature that homeless people have high levels of unmet health needs and that they use health services differently to the housed population.[74, 75, 79] These differences can be summarized under four headings.

1. Delayed Presentations.
2. Low usage of Primary and Preventative Services.
3. High usage of Hospital Emergency Department (ED) and Inpatient Services.
4. Low Usage of Hospital Outpatient Departments (OPD)

### **Delayed Presentations and Defaulting from treatment.**

Despite their excess burden of physical and mental health problems, homeless people avoid consulting health services resulting in high levels of unmet health needs.[2, 114-118] They also have poorer compliance with treatment regimes.[119] As a result, they are more likely to present with multi-morbidity and late in the course of their illness when symptoms are florid and/or overbearing.[80, 120]

Homeless people are also more likely to default from treatment. They often leave health services (most notably ED) prior to being fully treated.[116, 121-123] They also have a propensity to leave hospital prior to being deemed ready for discharge.[123] Lastly, they often miss or not turn up to pre-arranged appointments.[116, 121, 124]

### **Low Usage Primary Care and Preventative Services.**

It has been suggested that accessible and available primary care is a pre-requisite for effective health interventions with homeless people.[125] Unfortunately, homeless people are low users of primary care services and often have difficulty accessing such

services.[116, 126] This means they lose out on the advantages of primary care namely, continuity of care and preventative care.[127-129]

The reasons for non-registration include lack of entitlement/insurance [mainly in the US]; difficulties registering (mainly the UK); or competing priorities,[2, 130-132] Irish studies have replicated the international experience with between 24% and 45% not having a registered GP.[23]

This non-registration can be explained by factors associated with the nature of homelessness and factors related to general practice. Those associated with the nature of homelessness include the socially isolating and transient nature of homelessness; the difficulties transferring patient information from surgery to surgery; distrust of mainstream medical services; lack of awareness of how to register; and a dislike of appointments and waiting rooms.[133] The factors associated with general practice include perverse incentivization by the remuneration process for GPs whereby they are paid the same amount per patient regardless of the workload associated with that individual[134]; and discrimination against homeless people due to stigmatization by GPs and /or their staff.[131]

Even when registered, homeless people often cannot utilize their GP due to the distance between their hostel and the surgery and/or difficulties obtaining appointments.[135]

Homeless people are poor up-takers of preventative services.[136-138] Competing priorities interfere with homeless people's availing of preventative services.[2]

### **High Usage of Secondary Care Hospital and Inpatient Services**

In contrast to their low usage of primary care services homeless people are high users of ED with attendance rates between 2.6 and 5 times that of the general population.[139] They have been found to account for 40% of all attendances at ED and 30% of psychiatric attendances at some hospitals.[117 140] Many homeless people access ED as the first point of contact with the health services.[141, 142] It has been found that a small group of homeless people account for most of these ED visits.[81, 140, 143, 144]

In Ireland attendance rates have been estimated to be between 22% and 37% of the homeless population, compared to 16% for the general Irish population. O Carroll et al estimated that the mean attendance rate for 6 months was 2.1 visits. They also found 7% of homeless people accounted for 23% of admissions.[23]

The higher usage of EDs by homeless people has been attributed to the higher rates of chronic ill health, infectious diseases, mental health problems, substance abuse and decreased access to primary care (including distance from one's own doctor).[406, 145-146] Access to primary care services has been demonstrated to reduce ED attendances.[118, 147-148]

Despite the higher morbidity profile for homeless people, they have been accused of 'inappropriately' attending ED's with estimates of 46% of such attendances as being more suitable for primary care.[142, 149] Frequent ED visits result in frustration amongst staff, prolonged waiting times for all patients and fragmented treatment for the particular patient.[150] Some authors argued that such usage of ED was inappropriate for homeless people as it could not meet their complex health and social needs.[151, 152] Murphy has argued that 'rather than vainly attempting to make the patients appropriate to the service, (we) ... should concentrate on making the ED service more appropriate to the patient.' [152]

Homeless people have higher admission rates to general hospitals with rates ranging between 2.7 to 7 times that of the general populations.[81, 116, 126] An alternative approach is to estimate the prevalence of homelessness amongst hospital inpatients which in the US have varied between 5% and 46%.[153] In Ireland O Carroll et al found that of 355 homeless people 19% had been inpatients in the previous 6 months versus 14% of the general population.[23] They also found that 7% of those who were inpatients accounted for 29% of hospital admissions.[23] Homelessness has been found to be a reason for admitting a patient where their social circumstances rather than severity of their illness was the main determinant.[154]

Homeless people have longer duration hospital inpatient stays than housed patients.[155] On discharge, homeless people are often placed in inadequate accommodation that often predisposes them to readmission.[142]



**Low Usage Hospital Outpatients.**

As with general practice, homeless people are less likely to use OPD than the general population. In Ireland estimates for homeless people's attendance at OPD has been estimated at 28% over a six month period.[23, 66]

**Costs to Health Service due to Homeless People.**

The usage pattern of secondary care by homeless people has been blamed for creating unnecessary extra costs for the health service.[156-158] The excess costs have been estimated to be between \$512 - \$16,376 per hospital admission or \$50,000 annually.[159-161] Tuberculosis (TB) treatment for homeless people has been estimated to cost \$2,000 more per homeless patient than for a housed patient.[162] The cost of untreated drug abuse amongst a sample of 114 opiate users of whom 51% were homeless was \$5.086 million.[163]

**Specialised Services.**

Several studies have found that mainstream services do not provide adequate care for homeless people and are poorly designed for their needs. [2, 74-75, 164] For this reason, specialised services are designed specifically for homeless people. They are usually either delivered at sites homeless people frequent (e.g. hostels, food halls or drop-ins[165]) or are located at 'one-stop shops' where homeless people can address their health, housing and welfare needs on one site.[166]

The use of specialized services has been shown to improve access to primary care and decrease the burden on secondary-care services.[154, 165] They have also been shown to be accessed by homeless people with serious health problems.[63] Such services have been clearly endorsed by homeless people as preferable to mainstream service.[168-170] They find that services specifically tailored for homeless people are more positive and less stigmatizing and homeless people express a preference for the development of such services rather than improving access to mainstream services.[171-173] However, despite their popularity, it has been found that even these services are under-utilised by homeless people. This may reflect the significant reluctance of homeless people to attend to their health.[174]

An alternative but allied approach is the 'No Wrong Door' service delivery system which seeks to address the fragmentation of services for homeless people by advocating that whatever service is accessed by the homeless person, they should be offered the range of health and social services they require.[17, 175]

In Dublin, there are nine specialised Primary Care clinics. They are coordinated by an organization that I founded called Safetynet. I run three of these services and my practice runs another four of the services. These services are staffed by full time nurses with doctors coming in for clinics between one and four times a week (depending on location and need). Five of the services are specifically for the hostels providing accommodation for homeless people. One is based in a hostel which is accessible seven days a week (09.00-17.00) to all homeless people. Two of the services are based in drop-in centres and one is in a food hall all of which are open to all homeless people. In addition, there is a Mobile Outreach Clinic which was founded by myself, providing services three nights a week to rough sleeping and street working homeless people and two afternoons a week to the Roma Community.

One of the aims of this study is to find out why homeless people have differing HSU. To this end I will review and contrast models that have been developed to explain the HSU of housed and homeless people.

### **Factors that affect the HSU Behaviour of the General and Homeless Populations:**

It is well recognised in the literature that the decision to attend a health service is not simply contingent on the presence of symptoms, but on a complex concoction of demographic, psychological, familial, social and cultural influences.[176-178] In fact, people consult doctors with only a minority of the symptoms they experience (between one in 18 to one in 37 for adults).[179-181] This has been referred to as the 'clinical iceberg'. [179, 181] Interestingly, there seems to be no logical relationship between the severity of symptoms and the patient's decision to consult or not consult, with minor symptoms being brought to the doctor while major ones are ignored. [178]

The decision to seek help for a particular symptom or array of symptoms has variously been described under the concepts of 'consultation triggers'[178]; consulting behaviour[182]; health service utilization[183]; health-seeking behaviour[184]; help-

seeking behaviour[185]; and healthcare-seeking behaviour[184]. The consultation trigger, consulting behaviour and health service utilization approaches aim to describe the specific triggers/determinants that result in a person consulting a health professional. These approaches concentrate on the 'end point' usage of the formal medical system. The health-seeking and help-seeking behaviour approaches both concentrate on how one manages one's health where end point usage is only one factor in a series of possible formal and informal health-management strategies.[184] The difference between the two lies in the fact health-seeking behaviour does not require the interaction of a third party whereas help-seeking does. [185] Healthcare seeking behaviour focuses specifically on end point utilization of informal or formal health services.[184] All these concepts come under the wider conceptual model of illness behaviour as described by Mechanic & Volkart i.e. "the way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction."[182]

For the purposes of this research study the conceptual model of health service utilization (HSU) will be adopted as the focus is on the interaction between homeless people and formal health services.

There has been a vast array of factors influencing HSU identified in the literature. For the purposes of describing these factors we will use the categorization adopted by Campbell & Roland as outlined in Table 3.1 to compare the factors that affect the HSU of the general and homeless populations. Campbell & Roland summarized the psychological factors on consulting behaviour under the Health Belief Model. This posits that there are four characteristics that determine help-seeking behaviour: perceived susceptibility to illness; perceived severity of the symptoms; perceived costs (monetary and other) of different health seeking behaviours; and perceived benefits of action (including belief in the efficacy of the doctor).[176]

Campbell & Roland added other psychological factors outside the health belief model for which they had identified evidence for in the literature.

**Table 3.1 Categorization of Help-Seeking Behaviours for the General Population. [176]**

- Socio-demographic factors:
  - Age
  - Gender
  - Ethnicity
- Socioeconomic factors:
  - Social Class
  - Unemployment
  - Familial and social network influences
- Psychological Factors:
  - Perceived susceptibility.
  - Perceived Severity
  - Knowledge about illness and information seeking behaviour.\*
  - Belief in the effectiveness of healthcare.\*
  - Belief in the effectiveness of self-care\*
  - Stressful Life Events. \*
  - Perceived benefits and costs of obtaining healthcare.
- The Organization of Healthcare:
  - Distance from Surgery
  - Appointments Systems.
  - Doctor Initiated Consultations.
  - Access to Emergency Departments.

\* Added by Campbell & Roland.

### **Socio-demographic Factors**

**Age:** Consultation patterns in the general population show a U shaped distribution in terms of age with highest consultation rates by young children and those over 65 years. [105]

In contrast, older people from the homeless population are reluctant to attend health services.[186] This is despite them having up to 3-4 times more physical symptoms than the housed population, and being up to 3 times more likely to have an unplanned hospitalisation.[187] Over a quarter of older homeless people who die will not have had

contact with a health service during the illness that preceded their death.[188] Young homeless people avoid health services including specialised outreach health services.[174] This is due to a distrust of formal services (that can be explained by their own experiences of hurt and betrayal); a fear of exploitation; a belief in self-sufficiency; fear of lack of confidentiality; embarrassment; perceived medical incompetence; poor communication skills; and lack of finance.[189-190] However, they will attend someone whom they feel to be genuinely caring and effective at addressing their immediate needs e.g. a place to bed down.[190]

**Gender:** In the general population, women consult more than men, in particular between the ages of 16-44 where their consultation rates are twice that of men. Women are also more likely to be frequent attendees. This in part can be explained by consultations for maternity care and family planning.[176] The lower attendance of men has been related to a hegemonic view of masculinity that demands that men do not complain or seek help particularly for mental health problems.[190]

As with the general population, gender has been found to be a significant predictor of HSU for homeless people.[191-192] Homeless women seem to have different needs to homeless men, though the fact they are more likely to have children with them may explain most of these differences.[192] They do not perceive help seeking as a threat to their self-concept of competence or independence but they often lack the assertiveness skills required to obtain healthcare and describe seeking healthcare as ‘a constant struggle’.[192] They tend to be homeless for shorter periods; present with mental health rather than physical symptoms; use mental health and childcare services more often; and use drug, and alcohol services less often than their male counterparts.[191-192, 194] Homeless men, like their housed counterparts avoid seeking help for psychological distress in part due to the restrictive notion of masculinity. [195]

**Ethnicity:** Ethnic minorities have been found to have differing consultation patterns as cultural factors affect how symptoms are interpreted.[197] Minority groups face significant barriers to accessing health care including language barriers, cultural misunderstandings and prejudicial attitudes from medical staff.[198]

There is evidence, mainly from the US that homeless persons from different ethnic background use health services differently. African Americans tend to use informal (including familial) sources of support for health problems more than other homeless people. [199]

### **Socio-economic Factors.**

**Social Class:** It is well recognized that people from lower socioeconomic groupings have higher HSU rates even when account is taken of the higher morbidity they experience due to health inequalities.[200] Despite the poorer health however they make less use of preventative services.[176] Poor housing promotes a higher HSU pattern.[176]

Unemployed people are more likely to consult and those who are recently unemployed have particularly high HSU rates.[176, 201] This is partially explained by the high morbidity rates for unemployed people.[202]

This stress of being homeless can interfere with one's ability to seek healthcare.[203] People who have recently become homeless are more receptive to using health services than those who are homeless long-term.[204] However, chronicity of homelessness is associated with poorer physical and mental health and consequently, higher service usage.[24, 205] Competing priorities have been identified as a significant influence on HSU. Homeless people expend their energies on surviving to the extent that they have little time to concentrate on seeking treatment for their health.[2, 206] This is particularly so for older homeless people and those with mental health problems.[64, 207-208] These competing priorities include basic subsistence needs, housing, transport, employment, social welfare, prostitution, drug and alcohol misuse, drug-dealing, theft and begging.[91, 209] Homeless people who use drugs often avoid going for treatment for reasons such as physical addiction or enjoying the drug.[210] Unfortunately, the association between the reasons why homeless people fail to seek healthcare (e.g. seeking housing, shelter) and the behaviour of not seeking healthcare is bidirectional in that poorer health creates difficulties in addressing those same priorities that compete with the need for healthcare. [116]

**Familial Beliefs and Behaviour Patterns:** Families tend to have similar HSU behaviour due to socialisation and shared circumstances resulting in similar beliefs about the seriousness of medical symptoms and the value of medical care.[211] Some families have a

pattern of illness behaviour with high HSU rates.[212] Patterns of familial usage of health services can be transferred from generation to generation.[213-215] Family composition also matters with widow, divorcee and single-parent families more likely to attend.[164] In families, women have a particularly strong gate-keeping function for attendances at the doctor.[164]

Patients with good social networks are generally healthier and consult less often.[164] For every consultation with a GP, people have an average of 11 consultations with family or friends.[179] Having a poorly developed social network predicts higher attendances. [185]

### **Psychological Characteristics:**

A perceived need for help for a health problem demands that the subject develops and awareness of the need. The factors that help create this awareness are the presence, cause, significance, severity, consequences, duration, type and frequency of symptoms.[185] Symptoms refer to ‘subjective experiences reflecting changes in the bio-psychosocial function, sensation, or cognition of an individual, including signs.[216] Assigning meaning to a symptom requires one to assess it first, and this assessment requires both knowledge and reasoning.[217] The interpretation will depend on the nature of the symptom and how it affects one’s daily routine.[218] Ambiguous symptoms are less likely to result in a consultation.[219]

**Perceived susceptibility:** People who perceive themselves as being vulnerable and prone to getting sick are frequent attendees while low users worry less about symptoms they experience.[220] Not knowing the cause of one’s symptom believing the symptom to reflect an internal physical cause are more likely to result in one attending a doctor whereas the corollary i.e. believing one knows the cause of one’s symptom leads to a lesser likelihood of consulting.[221] A personal or family history of a cancer can either promote consulting behaviour in reaction to a symptom of such cancer or alternatively, due to the anxiety surrounding such a diagnosis promote non-attendance.[222-223] A perception of low-risk for cancer can deter consultation.[224] Having had the symptom previously and it being found to be non-significant (e.g. a benign breast lump) can promote non-attendance.[218]

There is little written on perceived susceptibility for homeless people in the literature.

**Perceived Severity:** Beliefs that a symptom is severe and that it will not respond to over the counter care make consultation with a doctor more likely.[225] Severity can be related to the intensity, frequency or the worsening nature of a symptom. Worsening nature has been found to be the best predictor of consultation presumably due to the anxiety created that their health is deteriorating.[226-227] Patients tend only to consult with pain when the intensity becomes unbearable.[178] How the severity of a symptom interferes with one's daily routine has been found to be more important than the intensity of the symptom e.g. pain has been found to be less predictive of consultation than disability resulting from that pain.[228]

There is little in the literature exploring how perceived severity affects homeless persons' HSU. Interestingly, objective level of need is not a good predictor of service usage for homeless people.[164] Hitting 'rock bottom' or 'being out of control' has been cited as a reason for seeking substance misuse treatment with 80% citing physical health as being the main motivator.[229-230]

**Knowledge about illness and information seeking behaviour:** A person's understanding of the significance of a symptom is dependent on their knowledge both factual and experiential of that symptom.[176] Having factual knowledge increases the individual's sense of control and makes them less likely to attend for minor symptoms. Seeking information can be a common reason for attendance.[225, 227] For some people who need knowledge to cope with illness, this can result in high consultation rates.[231]

Homeless people often have poor knowledge of what services are available to them.[232]

**Belief in the effectiveness of healthcare:** A belief that GP care makes a difference increases the chance of consulting a GP.[225] Such belief is influenced by previous experience which if positive will re-enforce a belief in the effectiveness of healthcare and if negative will detract from such a belief as well as leaving the client frustrated and on occasion stigmatised as hypochondriac.[234-235] Individuals will always consider from whom they will seek help before contact is initiated. Factors that influence this choice include community and social networks, service characteristics and financial considerations.[236-237]



As with the domiciled population homeless, people who have a history of past service use are more likely to use services in the future.[191] May found that homeless people who had used services in the past were better able to identify their service needs. The corollary that those who rarely accessed services rarely may be among the least able to identify their service needs.[164]

In contrast to domiciled people's HSU, the literature on HSU of homeless people strongly emphasises the positive and negative aspects of how medical and administrative staff have treated homeless people in previous encounters. Many homeless people perceived that staff fail to demonstrate empathy, respect, demonstrate clear stereotyping and prejudicial attitudes and actively discriminate against homeless people.[37, 53, 55] McCormick & Macintosh noted "homeless persons identified that providers imposed social distance through their use of language, lack of trust, and disrespect for age, which forced these participants into isolation from society. Social distance was reduced when providers accepted and respected the homeless person, making navigation through the sector accessible." [239] Ambrosio et al found that 31% of homeless people attending the ED felt they had been treated rudely, 45% felt their problem had not been taken seriously and 42% sought a second opinion for the problem they had presented with.[240] Homeless youth found parental and authoritative styles of communication particularly offensive.[164] Such perceptions result in a distrustful attitude towards health professionals and a decreased likelihood to consult a health professional or comply with treatment.[164]

It should be noted that homeless people have often had childhoods defined by neglect or abuse and have a difficulty trusting others anyway. Such distrust can be a cause of misinterpreting the motivations of others including health professionals. This could be a contributor to their perceptions of mistreatment by health professionals.[241]

Where homeless people perceive a health professional to be genuinely caring and interested in their welfare, they are more likely to trust and engage with the service in which the professional works.[91, 238, 242-244]

**Belief in the effectiveness of self care:** Patients make a provisional diagnosis of their own condition and then decide on a course of self-care.[177, 185 245] People with a strong belief efficacy in cross the counter medication or other remedies are more likely to self-

treat.[226] When the self-care fails they reconsider taking into account how the symptoms are interfering with their occupation and leisure activities and whether the condition could be something serious and decide whether to consult or not.[293]

The lack of resources contingent with homelessness compromises homeless people's HSU. Consequently, they defer seeking healthcare until they encounter a crisis. They cope in the meantime by developing their own healthcare management strategies.[246]

**Stressful Life Events:** When an individual is undergoing a life stress the presence of an ambiguous symptom is more likely to result in a consultation. However, if the stress is of recent onset it may be perceived as an explanation for the symptom and thus result in non attendance. Symptoms that are clear indicators of disease usually result in a consultation irrespective of the presence of stress.[247]

In discussing stress in the context of consultation rates, it is important to distinguish between self-reported stress and stressful life events. Stressful life events are associated with a higher consultation rate for the period of stress. Self reported stress is likewise associated with a long-term higher consultation rate.[176]

There is little written on the effect of stress on homeless people's HSU.

**Perceived benefits and costs of obtaining healthcare:** The likelihood of attending a health service increases once the perceived benefits of healthcare outweigh the perceived costs or risks. The benefits relate to whether the person believes the health service can relieve their symptom or cure the disease causing it. The level of benefit that can possible be gained relates to the perceived severity of the symptom; the perceived seriousness of possible diseases causing the symptom and the level of associated anxiety; and the effect of the symptom on the persons daily life including whether they need to return to work.[244 248-249] High users of health services tend to have strong faith in the doctor's ability to address the symptom/disease whilst the corollary applies to low users who have not such trust in the doctor's ability.[221]

People who present late with symptoms tend perceive more risks in disclosure.[250-251]  
The possible costs/risks that can be incurred in seeking care include:

- Financial costs such as cost of prescriptions cost of transport, cost of loss of work.[252] It has been estimated in Ireland that 4.4% of non-paying patients and 26.3% of paying patients do not attend with medical symptoms due to cost.[253]
- Physical costs include the efforts required to attend (especially for those with disabilities), difficulties obtaining transport and the possible side effects of investigative procedures or drugs.[254]
- Time costs. Many people do not wish to give up time out of their daily life to attend the doctor.[252]
- The risk of receiving a serious diagnosis that would have serious impact on one's health or mortality. Some people would prefer not to know.[222]
- The risk of being admitted into hospital. Some people have a blanket fear of hospitals. [255]
- The risk of receiving a psychiatric diagnosis.[226] One third to one half of people who suffer from depression never seek help and one half do not seek treatment in the first year of depression.[256-257] Farmer et al found that this reluctance to attend could be attributed to protection of self-identity.[258]
- The risk of receiving a stigmatizing diagnosis. Diseases where causality is uncertain and for which treatment is ineffective have the potential to become stigmatizing.[259] Some patients fear being labelled as hypochondriac.[164]
- The risk of embarrassment especially for intimate symptoms.[164]
- The decision to disclose a symptom that has created a fear of cancer occurs after a process of symptom interpretation and the weighing risks and benefits of disclosure. The particular fears include fear of hospitalization / treatment / surgery and the fear of possible loss of self identity.[260-261]
- The fear of being treated rudely or insensitively can result from previous such experiences and result in a low consultation rate.[164]

Homeless people do recognise the benefit of having good health which is contrary to most health professionals presumptions.[164] However, it has been recognised homeless people go through a complex decision making process where as they become entrenched in homelessness, the perceived benefit of services declines as the perceived costs of accessing those services increases.[91, 262, 263]

### **The Organization of Healthcare.**

The availability of services affects usage of those services. There are a number of factors which affect such availability.

**Distance from Surgery:** Distance from the surgery has an inverse relationship with utilization with people in rural areas being less likely than urban residents to consult but even in towns those farthest from the surgery being less likely to consult.[164] Older people with mobility problems, disabled people and those without a car have particular difficulty.[241]

Distance is a very significant factor that deters homeless people attending their doctor as their homeless accommodation is often situated far from where they originated.[121-122, 124, 264-265]

**Appointments Systems:** Appointment systems act as a barrier to access in particular for those from lower socio-economic groups.[176, 219] High attendees are more likely to appear without an appointment or not appear for appointments they have made.[176]

As with distance, appointments are a barrier that often seems insurmountable for homeless people who have difficulty making, remembering and keeping appointments.[164]

**Doctor Initiated Consultations:** It is recognised that up to half of consultations may be doctor initiated.[227]

There is little written in the literature on the effect of this factor on homeless people's HSU.

**Access to Emergency Departments:** Having a local ED reduces consultation rates in particular for out-of-hours services. Some people do not understand the role of ED, for others GP appointment times are not soon enough, while others who have low faith in their GP and / or seek a more 'expert' opinion.[266] People who do consult ED believe that they do not take the decision lightly and believe other people abuse the system but not them.[214]

Homeless people's use of ED has been described in Chapter 2.

In addition to the factors identified as affecting the general and homeless population there are a range of factors identified as barriers for homeless people accessing health services in the literature that are unique to this population.[122, 267] As Pogo summed it up - *"we have seen the enemy and they is us."*[262] Stein 2007 found that the more severe a person's homelessness the worse their illness profile and the more insurmountable the barriers to healthcare.[268] These barriers can result in homeless people losing faith in the healthcare system.[268]

Brubaker et al describe barriers in terms of individual, programmatic and societal barriers.[269] Individual barriers are psychological or cognitive in nature.[269] These include difficulty remembering one's medical history, mental illness, feeling the emotions of despair or hopelessness or non-compliance with medication.[270-273] Programmatic barriers relate to those features of a service which make them inaccessible. These include administrative processes, restricted admission policies, abstinence requirements, medication policies, waiting lists, language barriers, discrimination by staff, poor service delivery etc. Societal barriers are those rooted in the social process that marginalise homeless people.[121, 273-275] These include fragmentation of services, poor employment prospects, lack of appropriate accommodation or health insurance.[36, 102, 276-279] Table 3.2 summarises the range of barriers faced by homeless people in accessing healthcare.

In summary, while there are similarities between the range of factors that affect the HSU of the general and homeless populations, there are a large number of factors that either seem to have a greater impact on homeless people or are specific to the homeless population. How does the literature explain this variation in influences?

## **EXPLANATORY MODELS FOR HEALTH SERVICE UTILIZATION**

It was only in the mid twentieth century that it was realized that the decision to consult a medical practitioner was not a purely rational decision based on medical need. In 1952 Zborowski found that people of UK or Irish background had a more stoical response to painful symptoms than those of Italian or Jewish background.[176] In 1954 Koos noted

that wealthy people were more likely to describe themselves as sick than their poorer counterparts independent of their actual health.[280]

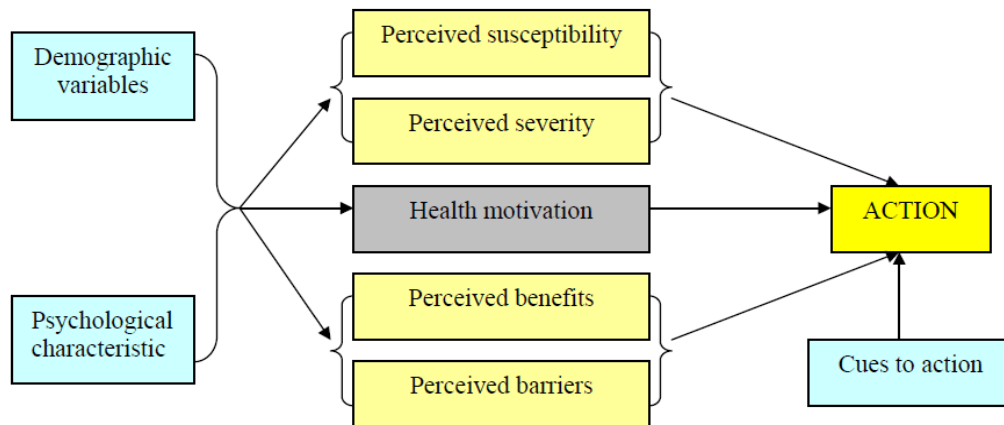
There have been a number of explanatory theories seeking to explain why individuals differ in their HSU. Mackian et al categorized these models under three categories.[281]:

- **Social Determinants Models:** Social Determinant Models seek to identify the factors that influence a person's health related behavior.
- **Pathway Models:** Pathway models seek to describe the series of steps individuals make when seeking healthcare. They do not seek to identify cognitive or determinant influences.
- **Community Focused Explanatory Models:** Community models focus on explaining community rather than individual's Health Seeking Behaviour.

In this literature review we will concentrate solely on the Social Determinants explanatory model and in particular the Health Belief Model (HBM) and the Anderson Behaviour Model which is an adaptation of the HBM. The reason for this is the only model proposed for the HSU of homeless people derives from the Anderson Behavioural model which itself derives from the HBM.

Social Determinant models seek to provide a categorization of the factors that influence individual's health seeking behaviour. Health behaviour is 'any actions undertaken by an individual which have the potential to influence health (e.g. diet, smoking, physical activity, consulting with health care professionals).'[282] There is dispute whether they are most suited to explaining or predicting behaviour. [183]

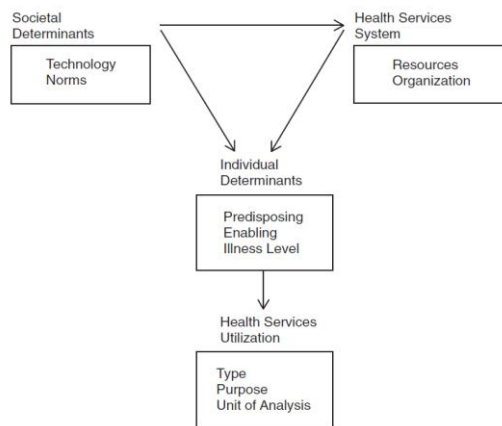
The Health Belief Model (HBM) laid the foundation for other determinants model of health-seeking behaviour determinant models. It was designed in the 1950's by Hochbaum, Rosenstock & Kegels who originally sought to create a psychological understanding of how people behaved in response to treatment for acute or chronic health conditions.[12] It eventually became a theory designed to generally predict health behaviours and is used mostly by preventative health services.[283]



**Figure 3.1 : The Health Belief Model[284]**

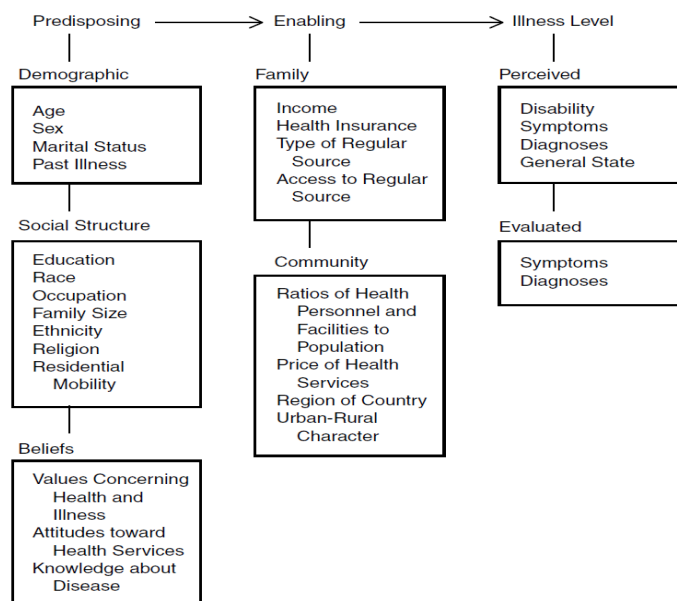
There are a number of studies that have lent evidential support to the HBM.[285-293] Perceived vulnerability has been demonstrated to affect consulting behaviour with those less anxious about their health less likely to consult. Perceived vulnerability also relates to 'locus of control' which has been shown to influence consulting behaviour i.e. whether the person considers they have the ability or not within themselves to manage the illness (i.e. internal locus of control) or whether they believe they have no influence (external locus of control).[105] Perceived severity has also been found to influence consulting behaviour. Severity not just relates to the intensity of extent of symptoms but also to the progress of those symptoms e.g. rapid progression or slow resolution.[176] Perceived benefits and costs have likewise been shown to affect consulting behaviour.[284]

Anderson's Behavioural Model is a highly influential development of HBM that focussed on end-point HSU and took into account the social context of behavioural action.[183] Equitable access is driven by demographic characteristics and need whereas inequitable access is a result of social structure, health beliefs, and enabling resources. Anderson introduced the concept of mutability i.e. the ability to change. Demographic characteristics are immutable whereas socioeconomic circumstances can be changed by Government action.[113] The Health Services/System refers to how firstly, how capital and labour resources are distributed and secondly, how the organisation of healthcare services creates or diminishes barriers to usage.



**Figure 3.2: Anderson's Framework for Health Utilization.[1]**

At the individual level, Anderson & Newman stratified determinants under predisposing variable, enabling variable and illness level categories.



**Figure 3.3 : Individual determinants of health care utilization.[1]**

The predisposing factors, that are independent of need, include demographic variables such as age and gender; social factors such as marital status, education, occupation, ethnicity and integration into social networks. Positive attitudes and beliefs about health services also predispose one towards service usage. Enabling factors include income, access to free health care, availability of transport and knowledge of available services.[1] Needs includes both perceived and actual need for healthcare.[1]



### **Explanatory Models for Homeless People's Consulting.**

In the literature on homelessness there are two explanatory models for homeless people's HSU, the first and adaptation of Anderson's determinants model and the second, a model that focuses on the concept of barriers.

Gelberg, Anderson & Leake adapted Anderson's Behavioural Model for HSU and produced the Behavioural Model for Vulnerable Populations (see Table 3.3). In this they maintained the original categorization of determinants that were proposed to influence behaviour but they divided each category into traditional domains (i.e. variables that applied to all people) and vulnerable domains (i.e. variables specific to vulnerable populations).[164]

The predisposing vulnerable domain includes social structure characteristics such as acculturation, immigration status, literacy, history of foster care, abuse or neglect, parental illness, lack of housing, poor living conditions, mobility during childhood, criminal behaviour, prison history, victimization, mental illness, poor psychological resources (e.g. low self esteem, low cognitive ability) and substance use.

The *Enabling Vulnerable domain* includes personal/family resources, such as receipt of public benefits, competing needs, and availability and use of information sources. The community resources construct includes community crime rates and the availability of social services.

The *Need Vulnerable domain* includes perceptions and evaluated need regarding conditions of special relevance to vulnerable populations, such as tuberculosis, sexually transmitted diseases, premature and low-birth weight infants, and acquired immunodeficiency syndrome (AIDS). When predicting the use of mental health or substance abuse services and related outcomes, mental illness and substance abuse would also be in this domain, rather than in the predisposing domain. Further, a clinician's evaluation of a patient may be affected by the patients' vulnerable status. Similarly, patients' perceptions of their health may be related to their vulnerable status.

*Personal Health Practices Vulnerable domain* includes food sources and hygiene and unsafe sexual behaviours.

The *Outcomes domain* transcends the traditional and vulnerable domains and includes perceived and evaluated health status and satisfaction with care.

Gelberg et al's model also recognizes the effect of 'realised access' on health outcomes which include health status, patient compliance, and consumer satisfaction. Health status operates as a feedback mechanism as improved health has a positive feedback effect on health utilization while non improvement has a corollary effect.[164]

As with Anderson's Model the evidence for the Vulnerable Studies have confirmed some aspects of the Behavioural model for vulnerable populations but not others and there is a frustrating lack of consistency in results. The model has been used in differing populations including those with mental health problems; substance mis-users; victims of violent crime; people affected by HIV/AIDS; and people in receipt of welfare benefits.[294]

Table 3.3: Gelberg Anderson Behavioural Model for Vulnerable Populations.[164]				
Predisposing Factors →	Enabling Factors →	Need →	Health Behaviour →	←←Outcomes
<b>Traditional Domain</b> <b>Demographics</b> Age Gender Marital Status.  <b>Health Beliefs</b> Values Concerning health and illness Attitudes towards health services. Knowledge about disease  <b>Social Structure</b> Ethnicity Education Employment Social Networks Occupation Family Size Religion	<b>Traditional Domain</b> <b>Personal Family Resources</b> Regular Source of Care Entitlement to free primary care Income Social Support Perceived Barriers to Care  <b>Community Resources</b> Residence Region Health Services Resources	<b>Traditional Domain</b> <b>Perceived health</b> General Population health conditions  <b>Evaluated Health</b> General Population health conditions	<b>Traditional Domain</b> <b>Personal Health Practices</b> Diet Exercise Self Care Tobacco Use Adherence to care  <b>Use of Health Services</b> Ambulatory Care Inpatient Care Alternative Healthcare Long-term healthcare	<b>Traditional and Vulnerable Domains</b> <b>Health Status</b> Perceived Health Evaluated Health  <b>Satisfaction with Care</b> General Satisfaction Technical quality Interpersonal aspects Coordination Communication Financial Aspects Time spent with clinical Access / Availability Convenience Continuity Comprehensiveness Administrative Hassle
<b>Vulnerable Domain</b> <b>Social Structure</b> Country of birth Acculturation / Immigration / Literacy Sexual orientation  <b>Childhood characteristics</b> Residential History (e.g. foster care, orphanages) / Homelessness Living Conditions Mobility (stability of home) Length of time in the community Criminal behaviour / Prison history History of abuse or neglect Mental Health Psychological resources (self esteem, social skills etc) Substance abuse	<b>Vulnerable Domain</b> <b>Personal Family Resources</b> Competing Needs Hunger Social Benefits Self Help Skills Ability to negotiate system Key worker Transport Telephone Information Sources  <b>Community Resources</b> Crime rates Social Services resources	<b>Vulnerable Domain</b> <b>Perceived health</b> Vulnerable Population health conditions  <b>Evaluated Health</b> Vulnerable Population health conditions (e.g. TB, STD's, and HIV, Hepatitis etc and substance abuse and mental health problems).	<b>Vulnerable Domain</b> <b>Personal Health Practices</b> Food sources Hygiene Unsafe sexual practices	

Predisposing factors such as older age, female gender, unmarried status and higher education have been associated with higher health service usage. Awareness of services is related to service usage but good awareness did not automatically transfer into higher usage.[295] Chronicity of homelessness and mental health problems surprisingly predicted better health outcomes. [294, 296]

Enabling factors such as perceived barriers in the traditional domain and income and competing priorities in the vulnerable domain have been shown to predict HSU.[122, 282, 297, 164]

The best predictor of service usage has been identified as perceived need.[298] However, the evidence supporting actual need as a predictor is mixed. The presence of substance misuse does predict chronic ill health and HSU but severity of illness (in relation to skin infections and ulcers) or interference with daily activities does not.[296] Unexpectedly homeless people have been found to be more likely to consult for conditions that would have long term consequences whether symptomatic or not.[298] Lim found similarly, that actual need for homeless women was not a good predictor for hospitalization but was for primary and preventative care.[297]

The second explanatory model involves a focus on barriers faced by homeless people accessing healthcare first devised by Penchansky & Thomas. They posit that HSU depends on the “fit” between individuals (clients) and the health care system.”[299] This fit can be measured in terms of the availability (has the provider the necessary resources to meet the needs of the client); accessibility (this refers to geographic accessibility); affordability (can they pay for the service); accommodation (are the services organized to meet address constraints faced by client); and acceptability (how comfortable the client feels with the provider individuals and organization) of health services.[300] Of note this chain is only as weak as each as the weakest link i.e. it only takes one of these factors to prevent access[301] This model focuses on the interface between the service and potential client and how engagement can be affected by the characteristics of either service or potential client.[302] While the barrier to access model is less commonly found in the literature as an explicit explanation for homeless people’s HSU, the description of barriers to access are pervasive in the

literature (see Figure 3.2).

### **Criticisms of Current Explanatory Models of HSU of Homeless People.**

The HBM, the Anderson Behavioural Model and its derivative, the Gelberg Anderson Model, are the most widely used models in investigating HSU behaviour. However, there have been criticisms of these models in the literature.

The main criticism is that while these models may serve as useful categorizations for factors that affect HSU, the actual effectiveness in predicting behaviour is at best minimal.[284, 303] Babitsch et al conducted a review of studies that used Anderson's Behavioural model including those using the Gelberg-Anderson model for Vulnerable Populations. They found 328 studies but had to exclude the vast majority due to the studies focusing on too specific a disease or service area. They were left with only 16 studies. They found firstly, that only a few of the variables from the model were actually explored in the research. They felt this was probably due to authors making pragmatic research decisions. Secondly, while there were repeated associations between the various predisposing, enabling and need factors identified, the direction of these associations was on occasions contradictory and overall there was a lack of consistency in results They attributed this to the nature of variation in subject area explored and the fact that many of the studies were using secondary data sets. They concluded "the explanatory power of the results is restricted and is often limited to single indicators" and recommended primary research studies be conducted.[294]

A second criticism is that Gelberg & Anderson's model does not place enough emphasis on systemic or policy effects on populations HSU. Derosé et al noted that while there were recent attempts to use the model to address the influence of policy on HSU, most applications of the behavioural models focused at factors at the individual level.[300]

In summary, it is clear that homeless people have worse mortality and physical and mental morbidity profiles than the general population. Despite this worse profile they have differing HSU behaviour to the general population which results in delayed or non treatment of their health conditions. They use health services in a seemingly ineffective manner with an over-reliance on ED and inpatient hospitalization and an under-utilization of OPD, mental health, primary care and preventative services.

There have been significant differences noted in the factors affecting the HSU of homeless people and two models, the Gelberg Anderson model and Barriers model have been developed to explain these differences.

However, gaps remain in the literature. Neither the Gelberg Anderson nor the Barrier models have yet been clearly demonstrated to reliably predict or explain the HSU of homeless people. The Gelberg Anderson model focused on individual behaviours while the Barriers model focuses on system failures. In essence this reflects the agency-structure division and does raise the question of whether a theoretical model that integrates the agency-structure interaction would offer a more comprehensive understanding of the HSU of homeless people.

From a critical realist perspective there has been no attempt to identify the generative mechanism that result in homeless people having differing HSU behaviours from the general population. Also, studies to date have sought to predict or explain the HSU behaviour of homeless people but none have focussed on seeking to specifically explain why homeless people's HSU behaviour differs from that of the general population. Further, there are no studies that have explored HSU using an ethnographic approach. Lastly, there are no studies on the HSU of homeless people conducted in Ireland.

In summary, homeless people have a particular HSU behaviour in that they are likely to present late on in the course of their illness, have low rates of usage of primary care, preventative and outpatient services and high rates of ED and inpatient admission. This results in high costs to the health service. Specialised services improve access to primary care. The literature demonstrates that the factors affecting HSU differ for homeless people in comparison to the domiciled population. There are two explanatory theories for homeless people's HSU, the barriers model and the Gelberg-Andersen model for vulnerable populations. Both these have been criticised in the literature as not providing a comprehensive explanation for homeless peoples HSU.

<b>Table 3.2 Barriers to Access to Healthcare for Homeless People. (using Penchansky &amp; Thomas's Taxonomy).</b>				
<b>Availability</b>	<b>Accessibility</b>	<b>Accommodation</b>	<b>Affordability</b>	<b>Acceptability</b>
<ul style="list-style-type: none"> <li>- Lack of recuperative services for homeless patients.[304]</li> <li>- Fractured nature of service provision.[91 164 305]</li> <li>Physical conditions of homelessness affect patients' ability to store medication. [304]</li> </ul>	<ul style="list-style-type: none"> <li>- Inconvenient opening hours.[164]</li> <li>- No postal address for appointments.[116 121 124 305]</li> <li>- Inaccessible premises for people with disabilities.[304]</li> <li>- Lack of access to telephone to make or manage appointments.[164]</li> </ul>	<ul style="list-style-type: none"> <li>- Difficult registration procedures for entitlement to healthcare.[264]</li> <li>- Appointment systems.[164]</li> <li>- 'Being punished' for missed appointments.[238]</li> <li>- Long waiting times.[164]</li> <li>- Queues which are poorly tolerated by homeless people. [164]</li> <li>- Health care facilities not set up to care for homeless person.[304]</li> <li>- Lack of adequate discharge planning.[304]</li> <li>- Overemphasis on rules and regulations.[306 307]</li> <li>- Lack of continuity of care.[274 275]</li> <li>- Lack of knowledge of where to access services.[147308 309]</li> <li>-Administrative 'red tape'. [164]</li> <li>- Negative Attitudes of Health Professionals.[164]</li> <li>- Negative attitudes of Healthcare Administrative staff.[164]</li> <li>- Being stigmatized in healthcare facilities.[121 122 124 131 203 246 310]</li> <li>- Belief that homeless people are responsible for their homelessness.[164]</li> <li>- Refusing appointments due to previous transgressions. [108]</li> <li>- Stigmatization of alcohol and drug users amongst health professionals and their staff.[92 104 108 311-313]</li> <li>- Racist attitudes.[314]</li> <li>- Belief nothing can be done for addiction for homelessness.[305]</li> <li>- Belief women affected by domestic violence did so of their own volition.[305]</li> <li>- Authoritative or Parental Styles of communication.[164]</li> <li>- Lack of empathy.[53 55 190]</li> <li>- Feeling that problems are not taken seriously.[164]</li> <li>- Poor communication skills with drug users.[108]</li> </ul>	<ul style="list-style-type: none"> <li>- Financial inability to pay.[116 121 124 246 304 308]</li> <li>- Lack of affordable transport.[122 124 264-265 304]</li> </ul>	<ul style="list-style-type: none"> <li>- Distrust of perceived authority figures.[304]</li> <li>- Distrust of Health Professionals.[296 305]</li> <li>- Perception that facilities are not for homeless people.[305]</li> <li>- Feeling invisible to healthcare staff.[246]</li> <li>- Development of own self-care strategies.[246]</li> <li>- Fear of test results.[164]</li> <li>- Fear of psychiatric diagnosis.[90 169]</li> <li>- Fears of treatment.[298]</li> <li>- Fear of hospital admission.[169]</li> <li>- Fear of treatment failure (in the case of substance abuse treatment).[298].</li> <li>- Previous bad experience health service.[164]</li> <li>- Fear of involvement of childcare services.[147 314 315 316]</li> <li>- Lack of relationship with healthcare provider.[297]</li> <li>- Embarrassment due to poor personal hygiene.[170]</li> <li>- Poor assertiveness skills.[193]</li> <li>- Feelings of social class inferiority.[317]</li> <li>- Fear for safety.[315]</li> <li>- Confusion during previous encounter claiming entitlements.[314]</li> <li>- Lack of concordance between what homeless people want and what services provide.[318]</li> </ul>

## CHAPTER 4: RESEARCH METHODOLOGY.

*“Research is formalized curiosity. It is poking and prying with a purpose.”*  
Zora Neale Hurston, in *Dust Tracks on a Road*, 1942[319]

Methodology, which incorporates the research philosophy and strategy, is what formalizes the curiosity of research. This chapter seeks to outline the research strategy and methods including the philosophical presumptions underlying the research. It further outlines the limitations of the research design and how these affect the applicability of the research findings.

### **Research Methodology.**

The exploration of the HSU of homeless people has been researched through a variety of research approaches including grounded theory[124, 239] and cross-sectional surveys.[74, 116, 164, 320] To date ethnography has not been used to investigate this area.

*“Ethnography is iterative-inductive research (that evolves in design through the study), drawing on a family of methods, involving direct and sustained contact with human agents, within the context of their daily lives (and cultures), watching what happens, listening to what is said, asking questions, and producing a richly written account that respects the irreducibility of human experience, that acknowledges the role of theory, as well as the researcher's own role, and that views humans as part object/part subject.”[10]*

Ethnography offered a number of advantages as a research approach. The main aim of this research was to gain an insight into the HSU behaviours of homeless people and to develop a critical-realist, explanatory model for homeless people's HSU. As Kumar notes “understanding human behaviour poses a formidable challenge to social scientists as each person is different from all others in terms of outlook, genetic makeup, attitude, thought process and, above all, behaviour.”[321] Quantitative methods primarily explore behaviours while qualitative methods (other than ethnography) primarily explore health beliefs and intentions. However, it is well recognised that participants do not always do what they say they will do or/and often behave in ways they explicitly say they would not behave.[239] Ethnography facilitates the observation of behaviour and the exploration of rationale simultaneously at the moment the behaviour is taking place and offers insight into the processes both personal and external that result in the particular behaviour.[322-323]

For example, McVP-C had his ear badly bitten on the street by a stranger and told me he did not intend to go to hospital. When I informed him of the risk of HIV or Hepatitis he did go but later on when I met him I learned that he had left before receiving medical attention. On interviewing him, he said he thought he would be ok. I noted he seemed unafraid of the consequences of HIV or Hepatitis and that made me aware that homeless people's familiarity with people having HIV or Hepatitis may reduce their fear of those conditions.

Context is crucial to understanding behaviour.[324-326] Contextualization is a feature of ethnographic observation that produces an understanding of how contextual factors shape decisions and behaviours.[327-331] For example, I observed how homeless people queuing for specialised services in food halls or outreach services seemed happy and satisfied to wait. However, when homeless and domiciled people were queuing together in the ED waiting room, the atmosphere was uncomfortable and intimidating, resulting in the homeless people avoiding the waiting area. This helped me understand why homeless people do not like waiting in queues in 'mainstream' services and helped me understand why they preferred specialised services.

Lastly, in my work with homeless people, I had become keenly aware of the disempowerment experienced by homeless people and felt that such disempowerment must play a critical role in explaining their different HSU behaviours. Ethnography, offers an opportunity to critique the inequality inherent in social relations and how power is distributed and exercised in society.[332-336] The observation of power differentials was crucial in my understanding of how external factors affected participants' internal cognitive and emotional processes.

Neyland advises the development of an ethnographic strategy that addresses the following (what he terms) sensibilities[337]:

- Epistemological Approach.
- Location & Access.
- Observing and Participating.
- Field Relations.
- Ethnographic Time.
- Supplementing.



- Ethics.
- Exits

### **I. Epistemological Approach.**

I adopted a critical realist epistemology firstly as it best fits my own philosophical orientation and secondly, as its premises and approach offer several insights that seem to me to be compatible with the research subject.

Firstly, the dilemma in choosing a relativist versus realist epistemological approach lies in the fact that the decision to consult or not lies purely in the subjective realm. In addition, as has been strongly argued, the very concept of homelessness is socially constructed. However, even if it is a construction, those people identified as fitting this construction have definite poor health outcomes, differing consulting patterns and experience very harsh living circumstances. Critical realism (Bhaskar) offers an approach whereby the subjective experience of illness and one's reaction to symptoms can be explored while recognising that the actuality of homeless people's consulting patterns derives from generative mechanisms that exist in reality.[338-339]

Secondly, critical realism understands the world as being stratified into domains of the real (i.e the 'generative' structures and mechanisms that generate events, relations and discourses) which is inaccessible to our clouded perception; the actual (i.e. the events, relations and discourses that are caused by these generative mechanisms); and the empirical (i.e. our perceptions of the events, relations and discourses) which is observable and is part of the 'actual'. [340] This, according to Porter means that the agenda of critical realist research is to focus upon 'generative structures' as revealed by human agency since any explanation of social phenomena requires explanation at the generative level.[341] This approach is consistent with my own particular perspective which rejects the individualist approach that views the behaviour of homeless people to be the result of their 'feckless or lazy' or 'incompetent or less-able' nature. I believe that social processes generate these behaviours and, as a researcher, it behoves me to identify those generative mechanisms.

Thirdly, critical realism interprets causation in terms of tendencies as opposed to a simple

cause and effect model.[342-343] The outcomes are not pre-determined and often differ due to counteracting generative mechanisms or due to the vagaries of individual agency.[344] Furthermore, critical realism seeks to transcend the dualistic division between structural and agential understandings of social behaviour. Critical realists argue that social structure is an emergent entity from the actions of individuals.[33] Once created, these emergent powers have a causal influence on individuals but do not determine their behaviour.[338-339 346-347] My understanding of the literature on the HSU of homeless people and my own empirical experience of working with homeless people is that there is significant variation in HSU which can be due to both structural and agential differences. However, overall there is a general HSU tendency that can be identified and this fits into critical realists' understanding of causation as tendencies affected by both structural and agential factors.

Lastly, critical realism is under-laid with a value system that seeks to emancipate individuals from the negative constraints of social structures. Critical realism's task is to identify those generative mechanisms that will enable individuals to become aware of the choices they have. As Wilmott notes, this results in a 'happy confluence of science and emancipation'.[348] This would correlate with my own wishes that any findings from this research would to some extent contribute to emancipating homeless people from the reach of the generative mechanisms that negatively affects their HSU.

### **Critical Realist Methods.**

Critical realists are methodological pluralists, accepting that a variety of methods may be required to gain a fuller understanding of a social phenomenon and that [critically] will enable the creation of better explanatory theories at the generative level.[349] Thus, mixed methodology is encouraged to provide differing perspectives to enable a more coherent explanatory theory.[350] Critical realism also ascribes equal merit to academic evidence and 'front-liners' tacit knowledge.[351-352]

The variety of methods that have been used by critical realist researchers in order to identify generative mechanisms include ethnography, participant observation, semi-structured interviews, participatory action research, descriptive statistics,[353] quasi-experimental designs[354], focus groups [352], auto-ethnography[352], and triangulation methods.[248, 355-356] Triangulation is used not as a validity testing mechanism but

rather as means of developing a more holistic understanding of social phenomena so better theory can be created.[248]

Bhaskar maintains that a logical conclusion deriving from an emphasis on human agency is that social enquiry must begin with individual actors' experiential accounts. However, critical realist researchers have found that perceptions at the empirical level are often incomplete, inaccurate and ultimately fallible.[338, 357-358] Thus, as social scientists we must adopt a sceptical and fallible approach, whereby we critically analyse both participants accounts and our perceptions of events, recognising that they are saturated with individual, social, cultural and theoretical presumptions.

In this research I used Bhaskar's retroductive process to postulate the generative mechanisms for the HSU behaviours identified. Retroduction entails creating and testing theories so as to develop a 'best fit' explanatory theory. This differs from other inductive approaches (including Poppers falsifiability approach) which were created in the context of natural science, where causation is understood as being conjunctivist so allowing the development of predictive theories or 'laws' (e.g. water will boil at 100°C at standard normal pressure). Retroduction seeks to develop, critique and refine theories in order to identify best-fit explanations for tendencies as opposed to predictive laws of social occurrences.[338]

## **II Location & Access.**

### **a. Location.**

This study concentrated on exploring the Health Service Utilization of literal homeless people (i.e. roofless and houseless as described by the Ethos definition).[356]. The two explanatory models devised for the HSU of homeless people were devised in the US where homelessness corresponds to the literal homelessness definition. Thus I chose an ethnographic field of study (comprising 4 sites) that covered a population that almost totally comprised of individuals described as literal homeless. Lipscomb and McEvoy believe that critical realists should use multiple sites as this allows observation of the tendency of the same generative mechanism in different sites.[361-362]

I visited the Peter McVerry Trust Drop-in Centre on 10 occasions. This was set up by a Father Peter McVerry, an extremely well known and popular Jesuit priest who founded a

number of services for homeless people. This service is predominantly attended by young, male and female, homeless drug users. One rarely finds older homeless people or homeless people whose primary addiction is alcohol. There are homeless people with mental health problems who attend but they are invariably dual diagnosis with a co-morbid addiction.

I went out on the streets of Dublin at night time with the Dublin Simon Rough Sleeper Team [RST] on 15 occasions. They usually try and develop a relationship with each rough sleeper and then do a formal/informal needs assessment (depending on how trusting/distrustful the rough sleeper is). On two nights a week they accompany a mobile outreach clinic that is run by GP trainees to provide primary care for those people who wish to attend on the street.<sup>2</sup> The RST has found that such a service has a dual benefit. Firstly, it enables them to offer primary healthcare to homeless rough sleepers and secondly, they establish contact with rough sleepers who have previously refused contact.

I visited the Capuchin Centre Food Hall on 7 occasions. This is a well-known food hall based in North Dublin that distributes breakfasts and mid-day dinners to homeless people seven days a week. It is based in a building which is a large room with numerous tables catering for over 200 people at a time. There is an area for mothers and children to eat. The Hall was founded by Brother Kevin Crowley. It has a Safetynet run specialised clinic which is run by a nurse employed by the centre and doctors employed at my practice. The food hall is attended by a wide variety of homeless people including homeless drug users, homeless drinkers, homeless people with mental health problems, homeless family units (including single parents), people homeless due to family breakdown or unemployment and homeless non-Irish who became homeless due to unemployment during the recession in Ireland since 2007.

I visited the Mater Emergency Department in the inner city on 3 occasions. The hospital was built in the 18th century and is a beautiful, though run down period building. The Emergency Department is located at the back of the building in a 'supposedly temporary', very run down and spatially disorganised prefab building. The Emergency Department has a high rate of attendances by homeless people. It has a reputation for having long queues and many domiciled people will go to other hospitals to avoid attending it.

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<sup>2</sup> This service was initially founded by myself as Safetynet Chairperson in association with Dublin Simon, Chrysalis and the Order of Malta.

As the research progressed I made contacts with several homeless people who were willing to meet me at other locations e.g. a cafe for coffee and a chat or a hostel where they were staying. They did offer to bring me around for a day but due to my poor mobility<sup>3</sup> I declined any such offer.

My rationale for choosing these sites was that:

- a) They offered me access to a wider range of types of homeless groups.
- b) They allowed me access to both people who had been long-term homeless and people recently homeless.
- c) They allowed me access to homeless people in differing environments and contexts.
- d) One of the sites (Capuchin Centre) has specialised primary care services, one is connected with a mobile health clinic (RST) and one is a hospital ED department. This obviously has an effect on HSU. For this reason, it was also important to work in the McVerry Drop-in, where there was no medical service as was the case with clients in hostels and on the street I met with the outreach team.
- e) Multi-sited ethnography has been recognised as a valid form of ethnography. Indeed realist ethnographers claim it enhances validity as its findings are less likely to be influenced by the individual vagaries of a single unrepresentative site.[337, 359]

## **Access**

*“Negotiating access is a balancing act... gains and losses now and later as well as ethical and strategic considerations.”[30]*

I gained access to each of the homeless locations by informally asking the figureheads and/or managers of each service and then following up with a formal letter which gave details of the research and ethical permissions.

Hammersley & Atkinson pointed out how there can be multiple gatekeepers at different levels.[360] I was aware that having permission from the managers would not necessarily

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<sup>3</sup> I have a disability and as a result find walking very difficult.

convert into getting the ‘unofficial’ permission required on the ground. Therefore, before starting in any service I also met and informed the keyworkers of the research.

In all these cases my role as a doctor was pivotal in obtaining permission. I had established a medical clinic in the Capuchin Day centre which provides meals and other services for those in need. I had initiated a mobile outreach clinic to work with the Simon RST. I had worked on the Board of the McVerry Trust and had been Chair and Founder of their services’ subcommittee. Lastly, I was founder of a GP training programme in the Mater Hospital. There are instances of ethnographers obtaining access to fields using personal or work relationships.[363-364]

In each occasion where I met staff I outlined my role as a researcher and my research topic investigating homeless persons’ use of health services. I assured all of them I was not there to research or evaluate the staff. I answered any questions. Knowing keyworkers in these services proffered a threat as being seen to be ‘one of the helpers’. To counter this in the drop-in and food hall, once I was established in a service I went as if I were a ‘client’. This would mean greeting keyworkers (as any client would), but then going to the areas where the clients were congregating and hanging out there. I would circulate in the drop-in/ food centre, randomly. My impression was that staff would then not seek to interact beyond a simple greeting as my random wandering created an impression of ‘doing something’ and they learned to respect my necessity for non-engagement in conversation or discussion. On the streets, keyworkers would help make the initial contact with clients. Once I had made that contact I returned on my own to greet and talk to the client if they were amenable to discussions

In the Emergency Department I gained initial access through a consultant in the Emergency Department who also worked with me on the board of a homeless charity. He sponsored the application to the Hospital ethics committee. He then introduced me to the ED doctor, nursing, administrative and cleaning staff and allowed me to explain to them what I was doing.

As I noted above, there can be multiple gatekeepers to access at different levels. The final layer of access in all sites was to be accepted by and develop relationships with the homeless people in each service. When first entering the field sites, I found that I would

often meet people whom I knew as patients. They would often greet me warmly, talk to me for a while about general conversation and then ask what I was doing. I would explain my research purpose, at which time they would often engage in conversation about their opinions on how they used health services and what they felt was good or bad about health services. They would often then go on to introduce me to the group, usually indicating I was Dr Austin and in a manner that indicated I was 'alright'. Other people having heard of me and considering that I was good with homeless people would often strike up relationships. Some who had not heard of me would show polite interest, but usually engage. In terms of access, present or former patients, whom I had met on the field and with whom I had enjoyed a good relationship, acted as gatekeepers for me and allowed me access to other people. I also formed the opinion that respondents were, on occasion, appreciative of me as a doctor 'coming down to their level'. I was told on a number of occasions that it was great I had come down to do such research as it showed I cared.

In the McVerry Trust I was adopted by McVF-A<sup>4</sup>, a large, formidable and warm woman who had been in the Trust for years. She acted as a gatekeeper by introducing people to me and telling them to answer any questions I asked. I would joke with them how she was training me to be an interrogator so as to ease the conversation into a jokey, relaxed conversation and then would gradually introduce my research role.

Being a doctor who worked with homeless people caused difficulty as well. On one occasion, I was confronted by McVP-D<sup>5</sup> in the McVerry Trust, to whom I had refused benzodiazepines when he had seen me at a previous consultation. He became very angry and aggressive with me saying I didn't really care and coming down doing this research was a sham. He jabbed me repeatedly with his finger and raised his voice. This could have interfered with my ability to talk to other people in the drop-in as McVP-D was well known there. However, having calmed him down with the help of another homeless person and apologising to him for causing offence, we got into a conversation about how he had felt dismissed as a druggie when he had asked for benzos and how he had felt that I had no understanding or empathy for his difficulty coming off benzodiazepines. During the conversation I did clarify that, when asking for a detox off benzos, I actually had offered to conduct a detox using a protocol detox which required him doing preparatory work with a

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<sup>4</sup> See descriptors for participants in Appendix II

<sup>5</sup> As above

keyworker. However, he had interpreted the need to do this preparatory work as a rejection. I suggested routes he could access for a community detox. We subsequently got on very well and he became an informant for me in the McVerry Trust. The encounter in fact ended up being useful from a research perspective as it alerted me to the idea that a request for benzodiazepines can cause breakdown in a doctor-patient relationship and is a potential barrier to receiving healthcare.

In summary, I used four sites to obtain a multi-dimensional perspective on homeless people's HSU. I obtained access at several levels [managerial, staff and service users] by using contacts I had established in my role as a GP working with homeless people. I found that my identity as a doctor who had worked with homeless people had a significant influence on me obtaining access at all levels. What remained to be seen was would it have eventual losses due to its effect on field relations and quality of data.

### **III Observing and Participating.**

The first site I visited was the McVerry Trust Drop-In Centre. I made a total of 12 visits to the McVerry Trust, usually on a Friday, the day which I had reserved for my research. On two occasions I visited on a Wednesday morning just to ensure there were no significant differences in the clients attending and in the nature of participant behaviour. The clients of the service were generally in their twenties to thirties, both sexes, but about two thirds men. They generally wore tracksuits / hoodies / runners and looked like stereotypical 'drug users'. I would usually wander down and say hello to people in the garden and ask if anyone wanted a cup of tea. I would usually sit in the garden and position myself so as to be close, but not too close, to where the clients were sitting. Sitting there, but not looking at them, I would either wait for one of them to turn to me and ask me who I was or would take opportunities where there was a general conversation to join in by making some point or observation. Almost invariably they would respond and allow me in while asking me who I was. I always explained my role as a researcher and, where I was identified as a doctor, explain how my role as a researcher differed from that of a doctor.

My second research site was with rough sleepers where I accompanied the Simon Rough Sleeper team. I made 14 visits altogether, usually starting at 7pm and ending at 11.30pm. I also went out on five days to visit three particularly entrenched rough sleepers between the hours of 2pm to 6pm. The rough sleeper team worked in teams of two, each carrying



knapsacks with needle exchange equipment.<sup>6</sup> I accompanied them both as part of the outreach health-clinic (which often visited hostels) and on their street walks. I always informed any hostel staff of my research role and methods. When working with the rough sleeper team, both in hostels and on the street, I would slowly approach clients and ask if I could sit close to them. In the hostels this would be on a chair, on the street I would sit on the pavement using a plastic bag I brought to sit on. I would then engage them in discussion about general issues and, in the course of conversation, tell them about my role as researcher. I spent time with them. I reconnected with people I met either on subsequent visits on the street or in the hostels. On occasions I would swap phone numbers and arrange to meet particular individuals.

The third site I visited was the Emergency Department in the Mater Hospital. I was based in the waiting room which was a large square room full of plastic seating (40 seats altogether), with a large TV screen at the front. I sat in the room and observed what was happening. On occasions I also wandered outside the building where a number of patients, many whom I discovered to be homeless or drug users, would go out for a smoke and/or chat. I rarely engaged people in conversation in the waiting room as a generally tense atmosphere militated against conversation. Furthermore, it was not very private and many people would be listening in to any conversations that took place. The outside smoking area was much more convivial and enabled me to engage people in conversation quite easily. Again I explained my role as a researcher during the conversation. I only made three visits to the Emergency Department as I found that it yielded insufficient relevant data after the first visit.

The last setting I visited was the Capuchin food hall which I attended 8 times. This is a food hall in the inner city. Every day, large queues form outside in the early morning and at midday. Diners are served a high quality and substantial hot meal. They then sit in a large room which has seating for three hundred people and is usually full at peak times. There is an area for parents and children (with play areas and toys). At the end of the hall is a row of chairs where people queue to see the Safetynet doctor or nurse who works from a small room just off the main eating area.<sup>7</sup>

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<sup>6</sup> Of interest I am the doctor who provides clinical governance for the needle exchange

<sup>7</sup> See Appendix II for table of demographics, accommodation status and brief descriptions of field participants.

In all settings I adopted the position of the naïve questioner or acceptable incompetent. This is a rhetorical device to help explore presumptions that may underlay what the participant views as obvious.[337]

I conducted 47 semi-structured interviews with homeless people whom I met in the three sites as well as visiting various hostels I had established contact with through the Rough Sleeper team. The interviews ranged between 10 and 50 minutes in length. I used a Semi-Structured Interview Guide (Appendix I) I engaged with respondents at the site. I explained the purpose of the research and explained they did not have to do the interview if they did not wish to. I also offered to show them a written copy of the interview after if they so wished. I arranged to meet them usually in a hostel (if they were resident in a hostel) or else in a coffee shop or a drop-in centre e.g. Merchants Quay Ireland, the Capuchin Centre or the Granby Centre. I made 16 unsuccessful appointments, where the homeless person had left the hostel, did not want to get out of bed or did not turn up. When I met with them again I reassured them there was no problem about cancelling or not turning up. I asked if they were interested in re arranging, but that they were under no obligation to re- arrange. Twelve people re-arranged, of whom ten turned up while six did not rearrange.<sup>8</sup>

#### **IV Field Relations.**

A key issue in my fieldwork was the management of my relationship with the homeless people. I came across many people whom I had either treated as a patient or who knew of my reputation as a doctor.<sup>9</sup> Harrington noted that ‘‘*When ethnographers approach a research site, they will be defined in terms of social identity categories salient to participants.*’’[365] Goodwin noted how when she was conducting ethnographic research in a surgical theatre where she had worked as a nurse, participants often interacted with her as an ex-colleague despite the fact that she had clarified her role as a researcher.[366] This sharing of experiences with those being researched has been termed insider involvement. Both geographers and sociologists have explored how this can affect the research process,

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<sup>8</sup> See Appendix II for table of demographics and substance misuse; mental health; and Blood Borne Infection status of Interview Participants.

<sup>9</sup> I have been at the forefront of working with homeless people since the late early 2000’s and, for a period of several years, was the only doctor who provided specialised services in homeless services in Dublin.

in particular how it affects field relations and the validity of data.[367-370] In terms of field relations I had several concerns. In the event of role confusion:

- Respondents would be wary of me.
- I would have to deal with medical queries or requests for medical interventions;
- I would be asked to prescribe addictive medication;
- Respondents might be wary that I was associated with the social services and that I would report them on child protection issues.

While some of my fears were realised, they did not present to the extent that it prevented me from conducting my research:

- Some homeless people were wary of me being a doctor. These were invariably homeless people with negative experiences of the mental health services (usually compulsory admission or being put on medication they did not want to be on). As a doctor I could have viewed this as a result of the paranoia associated with their mental health diagnosis. As a researcher, it seemed an eminently reasonable fear and I understood their concern to avoid someone who could potentially incarcerate them against their will or put them forcibly on mind-altering medication.
- I addressed the issues of being asked to respond to medical concerns or to prescribe inappropriate medication in the ethics section. I encountered no situation where homeless parents worried about the fact that I could have raised child protection issues.

There were some advantages from being an insider in developing field relations which are recognised in the literature.[367] As an insider, I firstly had prior knowledge of where is best to obtain information. I also had prior rapport and trust with a number of the people I met on the field and, as a result, was often able to access informal discussion/gossip.

I adopted a number of strategies outlined in the literature to augment the potential advantages and to minimise the potential disadvantages of being an insider, in particular those of Wasserman & Clair.[371] I sought to make evident the differences between myself (a doctor) and the participants as this honesty then became the commonality that allowed acceptance within the group. Wasserman described how he became known by a group of homeless people as ‘the Professor’, yet was able to work with them as an ethnographer.[371]

I also sought to emphasise the similarities, while letting the differences fade into the background. As a researcher I wore jeans and casual clothes. I never introduced myself as doctor, but as Austin, and encouraged most people to call me Austin. In my interactions I found that I could use the North Dublin 'lingo'. This was not a deliberate ploy. I had worked in the inner city of Dublin since 1982 when I started working in youth clubs and had developed an affinity for Dublin wit and humour.

Wasserman & Clair recommend staying true to one's background and not to adopt positions or beliefs inconsistent with our own, just in order to gain access. [371] I have trained and worked as a counsellor and, in counselling, this concept is termed congruence i.e. authenticity to one's own values, emotions and beliefs. However, maintaining authenticity is a skill that requires knowing when to proffer one's opinions, how to disagree with other homeless people without causing offence (or on occasion how to recover when offence is caused). Thus, on one occasion when I was privy to a conversation slagging off gay people I was asked my opinion and I said I had no problem with people being gay and had a few good friends who were gay. One of the others in the room then joined in saying there was nothing wrong with being gay. I tried when speaking to sound non-assertive and non-judgemental by using a normal, casual tone of voice and proffering my opinion in a 'take it or leave it' fashion. I felt that this actually improved trust.

Lastly, Wasserman & Clair recommend "*the use of similarities to counterbalance difference, or the transforming of difference into advantage.*"[371] Thus, in conversations I often talked about places and people familiar to homeless Dublin people. I engaged in discussions about sport, particularly Gaelic football and often used the fact that my nephew played Gaelic for Dublin County in conversations which would generate great interest and discussion. When asked where I came from I would tell them how I came from Blackrock (a wealthy Dublin suburb) i.e. the difference, but would add that my Dad came from the north inner city and that I went to a Christian Brother's School (which many of the people in the research field did as well) as opposed to a private school i.e. the similarity, to give me some credibility.

Aside from Wasserman & Clair's approach, I also adopted Goodwin's strategy of constantly re-iterating my role in the field, as a researcher.[366]

### **Personal Safety**

It behoves a researcher to be careful about their personal safety.[372] In any field working with people there exists the potential for aggression and/or violence. This is particularly important when working with homelessness, where aggression and violence is pervasive.[373] I have detailed a number of strategies I used to ensure my safety in Appendix III.

### **V Ethnographic Time.**

I adopted an intermittent shortened ethnographic time mode.[374] I spent one half day a week conducting the ethnography between November 2010 and November 2012. I worked on Fridays but I also worked on other week and weekend days as well as nights in order to ascertain any differences that might relate to time of day or week. Savage noted that many health researchers adopted focussed ethnographic approaches.[322] The main reason why I adopted this approach was to fit in with my work schedule. There is no doubt that this affected my ability to 'immerse' myself in the field and inhibited my ability to develop strong relationships. However, the advantage of intermittent ethnography is that it enables part-time researchers to use ethnographic approaches. When (as in my case) researchers are working as practitioners in the field, they are able to bring their own experience and knowledge of the field and while recognising their potential biasing effect they can contribute significantly to the ultimate research findings. This should balance out to some extent the lesser propensity to immerse in the field.

### **VI Supplementing.**

Ethnographic research usually combines a number of different techniques, both qualitative and quantitative.[322] In my research I supplemented my research findings with two focus groups and 47 semi-structured interviews (ranging between 10 and 53 minutes).

I conducted two focus groups comprising both homeless people and junior doctors working in Emergency Departments in order to explore their experiences of each other. This opportunity arose from my work as Programme Director of the North Dublin GP Training Scheme. I set up this programme to train GP's to work in areas of deprivation and with marginalised groups. We had decided in conjunction with the Ana Liffey and Coolmine Projects to conduct two focus groups between homeless people and the doctors training on the programme (who at that stage of their training were in hospital work) and

ask each of the two groups to outline their experiences of each other. The purpose was to create a conversation that would challenge both groups stereotypes of the other. I recognised that this was an opportunity to explore homeless peoples' HSU in a setting where doctors would be outlining their reaction to that same HSU. After an information session, I obtained written consent from all participants and doctors (who were informed they did not have to participate or could participate but not consent to use their data).

The homeless people were recruited through the Ana Liffey Drug Project which works with homeless drug users. The focus group me with data that helped me develop lines of enquiry for my further research. Focus groups are widely used to explore people's understanding of illness and health behaviour and their experience of disease and health services.[65] The group process allows the participants to explore and crystallise their opinions on the questions posed by the researcher. It also permits the participants to generate questions the researcher may not have thought of.[291]<sup>10</sup>

Semi-structured interviews are designed to explore participants' point of view rather than their behaviour. Semi-structured interviews offer time and space that may not be available during ethnographic research to explore in-depth, complex questions. I used an interview schedule with pre-prepared questions, but also allowed myself the freedom to explore new avenues of enquiry that arose as the interview progressed.

## **VII Ethics.**

The research protocol was reviewed and approved by the Ethics Committees of the School for Health, University of Bath; and the Irish College of General Practitioners. At the start of my research I committed to underpinning my research with a pledge to participants' welfare (as advocated by feminist researchers[376]) and a commitment to remaining constantly reflexive on the possible implications of my actions.[366]

### **Consent:**

Consent is a key ethical issue, in particular with vulnerable populations such as homeless people. Several researchers have emphasized that consent is a sequential and continuously

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<sup>10</sup> See Appendix II for table of demographics, accommodation status and brief descriptions of focus group participants.

evolving process and so consent needs to be revisited as the process evolves.[362 373-378] During my research, when I felt the subject had become at ease with me and revealed information that may have been sensitive, I asked verbally for consent to include that information in my findings. Where I worked at a fixed site I put up notices announcing that I was doing research at that site (Appendix IVa & IVb)

I obtained written consent for taping and transcribing semi-structured interviews and focus groups. Each participant was given an information sheet on the research and this was explained prior to signing the consent form (Appendices Va, Vb & VI). Exclusion applied for the semi-structured interview and focus groups to take into account those who had diminished autonomy e.g.

- a. Those with mental health problems of a severity that affects their autonomy.
- b. Those who are under the influence of drugs/alcohol to the extent that it affects their autonomy.
- c. Those under the age of 16 years.
- d. Those with dementia (degenerative, infective or associated with alcohol).

In the ethnographic research the decision to include data on conversations with respondents who come under such exclusion criteria depended on the balance between benefits to be gained versus potential harms to the client. In reality, I met many people under the influence of alcohol or drugs, though rarely to the extent that I felt they did not understand the information I was relaying to them. At all stages every effort was made to emphasize my researcher role and ensure they were aware. However, on occasion I did include such information, but sought to meet the person the next day for permission. It is important to understand these groups' health-seeking behaviour as they are the least likely to access healthcare.[379]

I also informed all service-providers of my role as a researcher both as a group prior to starting my research and individually, where they had not been present at the original meeting. I emphasized my purpose was to research homeless people's health seeking behaviour, but that on occasion that may result in criticism of a service. I said I would inform each service of any criticism received. Ethnographers have often failed to let participants know that their findings may be critical of how an organization and its staff operate.[380] Ansbach & Misrachi suggest that any criticisms be voiced tentatively

towards the end of the process.[380] I took into account potential damage the organization/individual may sustain and how the loss of such data could affect the research findings.[380-381] At no stage was I asked to restrict the nature of the data I collected by service providers.

### **Confidentiality.**

Confidentiality can be difficult to maintain in qualitative studies due to the possibility of deductive disclosure whereby participants can be identified from traits or quotes.[382] In this research, the fact that the research was conducted at several sites and interviewees were drawn from a number of different sites and sources did improve my ability as the researcher to protect anonymity. In addition the data were anonymized by ‘cleaning’ it of identifying factors, both at the transcribing and data-cleaning stages. Anonymity does not guarantee confidentiality but does make it significantly more difficult to identify participants. Interviewees were assigned a code value which could only be accessed by the researcher.[383]

Information was stored electronically in a secure computer, stored in the researcher’s personal surgery. A back up was regularly created in an encrypted form on a hard drive that was kept at the researcher’s other place of work in the North Dublin City GP Training. Access was limited to the researcher and his supervisors. Paper copies of consent forms were stored in a secure, locked cabinet at the same location and could only be accessed by the researcher. Both electronic and paper data will be stored for 10 years prior to being destroyed.

### **Issues Pertaining to Professional Obligations as a doctor.**

I had to constantly address the issue of being a doctor in the field. Revealing this knowledge could have potentially biased an interview in that the participant could perceive a secondary gain in getting to know a doctor. However, keeping it secret could have led to a sense of betrayal for those participants who subsequently found out I was a doctor. Wasserman & Clair recommend truthfulness in this situation.[371]

On occasions, participants did seek medical advice or help on entering a service. They also sought my opinion regarding situations where they felt badly treated and sought



verification or refutation that such treatment was inappropriate or not. In these situations Van Maanen maintains that once we are accepted within a group we have an implicit contract to provide help when asked.[384] However, most ethnographers believe advice giving should be avoided as it prevents the researcher from keeping an appropriate distance and that it might produce a bias.[385-386] In these situations I clearly explained the boundaries between my work as a doctor and my work as a researcher. In interactions where I felt a homeless person had been unjustly treated and where there was a significant risk to their health, I brought it to attention of the relevant clinical person. When I was asked for medical advice, I advised that they attend a specialized clinic for homeless people or, (depending on the nature of the issue), the Emergency Department. When asked for addictive medication I apologized and said I was not allowed as a researcher to prescribe medication. When asked if I would in my clinic I again apologized and explained there was a clinic rule not to prescribe.

Issues did arise where I observed a homeless person's health to have been put at risk by people or institutions in the field. In these instances, I did intervene and used my professional expertise, but only in instances where I felt that there was a significant risk of the homeless person's health deteriorating due to the lack of an appropriate service. Such an intervention would be required by my Ethical Code of Conduct which demands that: a doctor's 'paramount professional responsibility is to act in the best interests of your patients. This takes priority over responsibilities to your colleagues and employers.' [387] For example, one respondent whom I met on the field (P-44) was sleeping rough and had been diagnosed with pneumonia. He had refused to go to hospital due to fear of hospitals. The keyworkers could not get him into accommodation. I rang the Freephone and a number of my contacts in hostels and succeeded in getting accommodation.

### **Focus Groups**

It was made clear in the focus groups that participants did not have to discuss challenging behaviours or drug-use unless they were comfortable with such disclosure. Participation in a group can result in individual members becoming distressed. I am a skilled facilitator and have experience with dealing with such events. Counseling was offered to any group member if they suffered distress as a result of the group process. No such requests were made.

There was a possibility that, within the focus groups, service users could have been inhibited by the presence of service providers. In order to prevent this I, as facilitator, asked a non-medical key-working colleague to co-facilitate the group with me. We sought to ensure that each participant's contributions were respected and valued and we checked with group members individually to ensure that the group process represented their views accurately.

## VII Exits

I spent two to three months at each site. I tried to manage exits sensitively. I informed participants from the start of when I intended to depart the field as advised by Neyland.[337] I discussed with them early on how we would manage any future relationship. I offered to show them any writings I produced in which they are mentioned. Having been a participant in an ethnographic study I recognize the sensitivities of participants in reading about themselves.

## VIII Data Analysis

I adopted Hammersly & Atkinson's suggestion that ethnography should have a funnel structure, starting off with broad area of research interest and gradually focussing down on a more specific research question. I used memos and field notes for the commencement of the analysis process, in order to gradually focus down. This analysis determined the direction the research took, focusing in on specific areas identified as being particularly relevant (e.g. internalised and external processes inhibiting or promoting HSU) while also opening up other unexplored avenues not identified in the research design phase (e.g. repeated interactions between health-workers and homeless people that inhibit or promote HSU).[342] Thus, analysis was both continuous and iterative as described by Glaser & Strauss.[388]

### Examples of Fields Memos:

- 9<sup>th</sup> January 2011 *'It did make me realise that .... he would be wary of getting involved with the Medical System which to us is a place of haven whereas to him it could be a place of threat...a threat of losing his children.'*
- 7<sup>th</sup> August 2012: *'This is example of firstly, an administrative barrier but secondly, a behaviour which may be a learned behaviour in reaction to previous barriers she has encountered but which has resulted in her losing the service. Need to focus on*

*how homeless people internalise barriers based on past experience of external barriers.'*

This dialectical interplay between data-gathering and analysis was contiguous with the reflective process whereby I reflected on my personal biases in gathering and analysing data as well as the biasing effect of my presence in the field.

Examples of Reflectivity on My Bias in Field:

- 3<sup>rd</sup> February 2011: *'He said "that's fine Doctor". I said "it's not doctor, it's Austin" but again it's that difficulty of been seen as the doctor instead of the researcher – people automatically see you in one role.'*
- 11<sup>th</sup> March 2011 *'As I was talking to her I started to realise how genuinely she really wanted to do a [benzodiazepine] detox and the depth of her belief that a detox would allow her get her life together... This made me reflect on how [as a doctor] I was more likely to believe the doctors perspective rather than McVP-K's perspective whom I still saw as a very likable but ultimately a distrustful drug user. Of note I had introduced myself to McVP-K as a researcher but she immediately had engaged with me as a doctor. As I was caught in both researcher and doctor mode I had possibly placed presumptions to the side I would have made...(as a doctor)...if I had not been in researcher mode. This resulted in a realization that I would not have made if I had been acting solely in my doctor role or had been perceived by McVP-K solely in my researcher role.'*

I transcribed the initial data so as to immerse myself in the data. Due to the volume of data for transcription I used professional transcribers for the majority of ethnographic notes and interviews. The data were loaded onto the NVIVO. I used Saldana's approach to coding to move from initial codes to conceptual categories.[389] Firstly, I performed a first cycle of open coding. A code is a 'researcher generated construct that symbolizes and thus attributes meaning to each individual datum for later purposes of pattern detection'

<b>Table 4.1 Coding Scheme.[389]</b>			
	<b>Coding Stage</b>	<b>Examples of Codes</b>	<b>Description and Use</b>
<b>Stage 1</b>	Open Coding	Drugs as treatment for illness; Living in the moment	
<b>Stage 2</b> Eclectic Coding (i.e. using a variety of coding methods at same time)[80]	Attribute Coding	Age, gender, housing status / history of drug use / alcoholism / mental health	The logging of essential information on participants and/or sites of investigation so as to allow systematic segregation of data based on source of data.
	Open Coding	Able to turn one's life round; Children are reason to live	As above.
	In Vivo Coding	'I survive'; 'I don't trust myself with me life when I get home'	In-vivo coding is where codes are derived from the actual language of the participants. It promotes findings emerging directly from the data.
	Sub-coding	Access to medical care – GP; Access to medical care – ED.	A sub-code is a second order attachment to a primary code to 'detail or enrich the data.' [80]
	Magnitude Coding	Promoter of HSU (strong); Promoter of HSU (moderate); Inhibitor of HSU [strong]; Inhibitor of HSU (moderate)	Codes that segregate data based on numeric formats (e.g. frequency; intensity or 'direction in a particular process, phenomenon or concept'). [80]
<b>Stage 3</b>	Categorizing, Themes or Pattern Coding	Bureaucratic Barriers to HSU; Emotions associated with poor HSU; Interaction patterns that inhibit HSU.	Categorizing involves clustering codes together based on commonalities into a fewer amount of larger groupings.
<b>Stage 5</b>	Concept formation	Internalised Cognitive Barriers to HSU; Influence of stigma on Interactions between Homeless people and health professionals	Labelling Patterns of HSU, identifying the internal and external influences on HSU, and the social determinants of such influences.
<b>Stage 6</b>	Theory Formation	An explanatory theory of HSU by homeless people	The process of theory building starts with describing the relationships and links between categories and developing an overall theory that informs and explains the data categories and linkages.

I adopted an inductive approach whereby the analysis was driven by the data, i.e. the codes and themes were not preformed prior to data collection and/or analysis, but derived from immersion in the data itself. This is opposed to deductive reasoning where the data are assessed to see if they confirm or refute a prior research hypothesis in the original research question.

My initial open coding failed to differentiate between important issues emerging from the data (e.g. I failed to identify emotional references within the data and it became apparent emotions were a significant factor in determining HSU) so I re-coded the data using eclectic-coding. I used attribute coding for both participants and ethnographic sites. I used a mixture of in-vivo, open, emotional, sub-coding and magnitude coding for the data. Using this approach I generated 741 codes.

<b>Table 4.2 Example of conceptual formation from categories:</b>		
<b>Category 1:</b> Presumptions of early death.	<b>Conceptual Category:</b>	<b>Conceptual Category:</b>  <b>Internalised Cognitive Barriers</b>
<b>Category 2:</b> Presumptions that personal health will not improve	Fatalistic Cognitions (linked to category of avoidance of HSU)	
<b>Category 3</b> Presumptions that will be dismissed by doctor as Drug Seeking	<b>Conceptual Category</b>  Presumption of Future Discrimination Cognitions (linked to category of avoidance of HSU)	
<b>Category 4</b> Presumptions of disrespect from doctor		

As I reviewed the data a number of categories (themes) started to emerge. I found myself using a process which correlated with Glaser & Strauss's constant comparative method, continuously comparing data appearing in categories, trying to identify differences between it and other data within that category and similarities with other categories. This resulted in the development of sub-categories; merging categories; the transformation of

vague categories into more clearly defined ones; and the re-assignment of a large amount of data between categories.[388]

Concept formation occurs when the categories become abstracted from reality into conceptual categories.

As the data analysis progressed it became clear that the constructed nature of homelessness resulted in difficulties discerning the actual effect of being roofless or homeless on HSU as distinct from the other elements that had been constructed into the concept of homelessness. One example was the stigma faced by homeless people a consequence of being homeless as opposed to being drug misusers or people with serious mental health problems or even both these factors. Throughout the analysis I sought to distinguish as much as possible how participants' roofless or houseless background in particular impacted on their HSU. The constant refinement and conceptualization of categories coupled with the identification of the relationship between categories resulted in the gradual development of an explanatory theory for the HSU of homeless people.

In examining categories I identified a number of generative mechanisms that helped explain why the HSU behaviour of homeless people differed from that of the domiciled population. These generative mechanisms had some direct effects on homeless people's behaviour but in the main, their influence was mediated by intermediate factors. I have categorised these factors under the concept of external barriers, deterrents and promoters, and internalised inhibitors and promoters. I linked these generative mechanisms and intermediating factors by examining the data for cross references to both and also using retroduction to identify the 'best fit' explanatory connections between them. I have illustrated these linkages in Chapters 6 & 7 in figures under each heading.

### **Trustworthiness or Validity.**

Lincoln & Guba refer to four elements of trustworthiness i.e. credibility [how congruent are findings with reality]; transferability (how transferable are the findings to other sites or populations); dependability (would another researcher with the same data produce the same findings) and confirmability (how much influence has the researcher's bias had on the findings).[4] I used a number of processes as recommended by Shenton to improve the trustworthiness of the findings.[3]

- Credibility was improved by:
  - Using triangulation (ethnographic observations; semi-structured interviews and focus groups). I have referenced quotes from these multiple sources in my findings.
  - Reviewing ‘negative’ cases where patterns differed from my findings and refined my findings as a result. Thus fear of bad news was identified as inhibiting participants from attending health services but fear of not getting treatment was also identified as a promoter of HSU.
  - Comparing my findings with previous studies to ensure concordance with previous findings so as to improve credibility. These studies are referenced in the results chapters.
- Transferability was improved by the fact I conducted my research at a number of different sites in Dublin.
- Dependability was improved by:
  - Describing the methods in detail.
  - Using overlapping methods such as ethnography, semi-structured interviews and focus groups.
  - For each of the themes I identified the number of sources and references for each theme. Saldana suggests this improves dependability.[389]
- Confirmability was improved by describing the reflections I engaged in regarding the potential biases emerging from my own personal views and from the nature and impact of my presence in the research field.

## **IX Methodological Limitations**

There are several potential limitations to this research.

### **1. Limitations pertaining to site.**

This research was conducted at several sites in Dublin city. While broad principles as to the consulting behaviour of homeless people have been outlined by this research, these primarily refer to homelessness in Dublin and care must be taken in applying them to other homeless populations.

## **2. Limitations pertaining to changing nature of homelessness.**

Any research, quantitative or qualitative is a snapshot at a particular time. Culture is constantly evolving and adapting to the relevant social context.[391] While this research was taking place, Ireland went through a severe economic crisis. This resulted in increasing numbers of people in homelessness and services reporting being swamped by new homeless people.[392] Thus the applicability of the research findings may be less relevant in less harsh economic circumstances.

As already noted, the constructed nature of homelessness can make it difficult to discern whether the observed phenomena were consequences of participants' homeless state or other factors associated with homelessness such as substance misuse or mental health problems.

## **3. Limitations pertaining to Insider Status.**

One of the chief limitations of this study relates to whether someone who works in a field can operate as an ethnographer in the same field. Finlay found the roles of insider and researcher had conflicting aims and objectives.[393] This could have influenced the validity of the research findings in a variety of ways.

Firstly, my prior knowledge of people I met in the field may have influenced my interactions and clouded my judgement. Gunasereka was tempted to fill in gaps in answers making presumptions based on knowledge of the respondent and based on previous conversations.[394] I met some respondents with whom I had unsatisfactory (and on occasion verbally aggressive) incidents, usually in relation to seeking benzodiazepines. I also found working with two particular clients whom I had encountered in relation to mental health issues and I had to be wary that these previous medical encounters did not cloud my interpretation of interactions with them.

Secondly, my personal involvement in the primary care services for homeless people and my allegiance to other medical colleagues in the same service created a significant risk of bias in the processing of data that is potentially critical of those services/colleagues. Dobson noted the danger of identifying with one's colleagues, being sympathetic to their perspective on their actions and dismissing opposing perspectives that contradict those of one's colleagues.[367] I did hear criticisms of hospital doctors, of fellow GPs and of



myself. Interestingly, I heard no criticisms of colleagues (nurse or doctor) working in the field of homelessness. This may have been due to clients not wanting to criticize my colleagues to my face. However, this interpretation is inconsistent with how easily they criticized hospital, psychiatric and GP colleagues and also criticised me to my face. The lack of criticism of fellow 'SafetyNet' colleagues is also consistent with the positivity noted in the literature, afforded to medical staff who work in specialised services with homeless people.[170]

Lastly, my role as a doctor, a role to which social authority is ascribed, could have affected the quantity and quality of data I obtained. Homeless people may have avoided talking to me or sharing information they might share with a researcher whom they perceived to be on 'the same level'. Respondents might have changed their mode of interaction and type of information they shared with me due to me being a doctor. There was no doubt this occurred with some clients. Some clients who wanted to ask me for a favour e.g. to take them on as a doctor, to give them benzodiazepines sounded as if they were trying to please me. Those seeking benzodiazepines in particular would seem to emphasize to me how they wanted to come off drugs and it was hard to distinguish the genuineness of this desire. When I sought to explore this issue I found myself being unsure of the veracity of their responses. For they could conceivably be of the opinion that it would be better for me to believe they wanted to come off, as then I would be more likely to give a detox if I met them in the future as a doctor. This inability to distinguish the truth mirrored the situation I have often found myself in as a doctor when people come in with very sad stories accompanied by a request for benzodiazepines. Exploration of this limbo between truth and deceit helped me gain some understanding as to why requests for benzodiazepines can lead to breakdown of a doctor-patient relationship as trust is perceived to be a pre-requisite for good doctor-patient relationships, a presumption I came to doubt.

I adopted a number of psychological and sociological strategies that are recognised in the literature to minimise the perceived disadvantages of being an insider. Firstly, I used my awareness of the psychological theory of 'transference' and 'counter-transference' issues to help address situations where I was being treated as an authority figure.[391-392] Transference can evoke positive or negative emotional responses and, in a population such as homeless people, where significant others have often been either punitive, neglectful or absent, transference reactions are likely to be more often negative. This carries a higher

chance of a negative counter-transference. CapP-E had often attended me as a doctor and had a tendency to have long consultations. On more than one occasion she pointed out that I was a doctor and should listen to patients and their concerns. This would annoy me. I interpreted it as a transference–counter-transference reaction. I always noted a tension when I saw her, knowing that consultations could be long and could engender unwelcome emotions if we engaged in the process of ‘you should hurry up’ / ‘you are a doctor and should be there for me’. When, I met her in the field, interestingly, I felt no such tension and enjoyed a very interesting conversation. I had become freed up of the time pressures and noted that I became more caring and she seemed to be happier. While we did not have a doctor-patient relationship at that time, she asked me for advice on managing her child to which I responded that I was no expert in child management. However, I offered some suggestions based on my own experience as a parent. This helped transform the dynamic somewhat.

The second strategy I used to help reduce bias was to obtain an appropriate balance between involvement with and detachment from those participants in the research field. Involvement can generate useful data once the researcher can recognise that the data was generated from an involved position and so recognise the potential limitations of that position.[397-400]

Thirdly, I adopted a reflexive approach in conducting the research and analysing the data. Reflexivity involves exploring how we as researchers with our emotional, value, attitudinal and cultural baggage are influencing the research process including the design, field work, analysis and conclusions. Reflexivity recognises that the researcher carries such baggage, and in order to make their findings as relevant as possible, they have to explore and recount how their own ‘baggage’ has affected the research and, when required, revise the research process or findings based on such reflections. Though, reflexivity was originally developed within the social constructionist tradition,[401] critical realists perceive reflexivity as the means of exploring how our epistemologically fuzzy perceptions of the research data may be preventing us from identifying the ontologically real generative mechanisms at play in explaining our data.[337] In exploring one’s involvement, an insider is simply ‘more involved’ and must reflect on how such increased involvement affects the research findings. However, the researcher also needs to be aware that conflicting perceptions of the processes at play generated from the different positions of insider and

researcher can result in a creative dissonance that can generate meaningful data.[394, 402] Reflexivity also helps in achieving that fluid dynamic between alternate states of involvement and detachment.

There have been a number of the criticisms of reflexivity:

- Reflexivity should not replace other markers of validity such as counting how often a theme appears, using conversational analysis to decipher meaning and negative case finding.
- Reflexivity can shift the focus too much onto the researcher deviating it from alternative data that may be more useful for data analysis.
- The accounts created by ‘reflexive’ researchers have been challenged as being ‘sewn up’, formulations that are inconsistent with the messiness of real data generated from the research field.[367]

Dobson suggests that in light of these criticisms, reflexive accounts should be tentative and cautious.[57]

As well being a source of possible bias, there were advantages in interpreting of data derived from being an insider. Firstly, as an insider I had prior ‘tacit and contextualising information’ of the field.[359, 367, 402-403] The tacit knowledge (which has the potential for bias as already described) was also available as a form of triangulation for validating data from research observations.[402, 404]

Secondly, as an insider I had prior knowledge of the field and subjects, though this could prevent me seeing with ‘fresh eyes’ it did allow me access to aspects that a non-insider may not be aware of. These include the language, phraseology, ritual, social relations and hierarchy within the field.[367, 394, 403, 405]

Lastly, I also found that on occasion I was aware of information that either contradicted, or gave an alternate perspective on the data I collected from research participants. Dobson gives an example of where she knew and could demonstrate how data received in interviews with some research subjects was misleading.[367] In my research, a number of, homeless drug users reported going to GP’s seeking benzodiazepines. I grew to understand

that from their perspective if they did not get benzodiazepines they would go into withdrawals and ‘get sick’ and so I understood why they got angry when refused. I also understood GP’s feelings of anger when asked to give benzodiazepines because ‘bad doctors prescribe benzodiazepines.’ Thus I obtained insight into why GP-patient relationships often failed to progress or irrevocably broke down over the ‘benzo conversation’. From a critical realist perspective this is using information from differing perceptual standpoints to contribute to the development of an explanatory model for the generative mechanism that results in a tendency for homeless drug users not to have a GP.

Lastly, I used several research methods to investigate the research questions. Triangulation can serve to sound out whether the insider involvement has detrimentally affected the data or interpretation of same.[406]

#### **4. Limitations pertaining to Sole Coder and Analyst of Data.**

As the sole researcher I was the sole coder and analyst of the data.

## **CHAPTER 5: HOW HOMELESS PEOPLE IN DUBLIN UTILISE HEALTH SERVICES**

The focus of this research was to develop a critical realist explanatory model for homeless people's Health Service Utilization (HSU). I identified a number of HSU behaviour patterns in this study that are consistent with the literature. I also identified several generative mechanisms that I perceived to contribute to the particular HSU tendencies of participants. Some of these had positive influences on the participants' HSU while the majority had negative influences. Some of these mechanisms preceded the person becoming homeless, some took effect during the process of becoming homeless and some emerged after the participant became homeless. Crucially, I identified that the manner in which these mechanisms operated was either through creating external barriers or deterrents or through the participants internalising a tendency to consult or not to consult. These internalised tendencies I interpreted as cognitions and emotions which either promoted or inhibited the participants' use of health-services. I distinguished between external barriers (which prevent HSU), external deterrents (which deter but do not prevent HSU), external promoters (which increase the tendency for HSU), internal promoters (which increase the tendency for HSU) and internal inhibitors (which decrease the tendency for HSU). It should be stressed none of these categories are neat and totally distinct from each other e.g. when a participant repeatedly meets an external barrier they often internalise an inhibiting cognition of 'what is the point?'

In this chapter I will outline what I believe to be the key differences between the HSU behaviours of homeless peoples and that of the housed population. In Chapter 6, I will outline the key generative mechanisms that laid the foundations for these external and internal influences on homeless people's HSU. Some of these had direct/proximal effects on participants HSU which I will describe. However, others had more distal/downstream effects through creating external barriers, deterrents and promoters and internalised inhibitors and promoters. I describe these in Chapter 7.

Participants identified a number of Health Service Usage behaviours that seemed particular to homeless people and are consistent with behaviours described in the literature. These behaviours included:

- Delayed (Leaving it till the last minute) presentation at health service.

- Defaulting from treatment.
- Low (often described in the literature as inappropriate) usage of Primary Care Services.
- High (often described in the literature as inappropriate) usage of Emergency Departments.
- Poor compliance with medication.
- Avoidance of Psychiatric Serv.

**Delayed presentation for treatment.** (39 sources/75 references).

Many participants delayed presenting for treatment. P-19: *'It just.....I didn't think I could die or if I cared...I kind of waited and waited 'till the last minute before I'd do something about it.'*

I directly observed 14 incidents where participants delayed presenting with serious conditions e.g. McVP-C had decided not to go to ED after a stranger had half bitten his ear off. I pointed out to him he could get HIV or Hepatitis. Even then, he left it for half a day before going to the ED.

I also heard 11 specific accounts by participants recounting how they had delayed presenting with health problems. P-6: *'Before, if I was ill...let's say flu, I'd just let it go by, but last year I had a serious complaint, I had blood poisoning...and blood clots in my leg and I actually walked around for...a week and a half because I didn't know what to do.'*

<b>Table 5.1: Conditions for which participants delayed presenting to health services.</b>		
<b>Condition</b>	<b>Delay</b>	<b>Respondent</b>
Abscess with weight loss and pain	3 weeks	McVP-I
Abscess post stabbing	6 days	McVP-J
Drug related abscess	Till red line travelled up leg.	P-23
Deep Venous Thrombosis	1 week - Did not attend	McVP-H, P-16, FG2P-C, P-6
Pyorrhoea and Loss of teeth	Did not attend	McVP-D
Human bite to ear	Did not attend	McVP-C

Pneumonia	4 days – Did not attend	CapP-G P-4 P-48
Severely swollen red eye	2 days	RSTP-T
Split lip requiring stitching	Did not attend	RSTP-S
Arm laceration requiring stitching	Did not attend	RSTP-R
Hepatitis C	Did not attend	P-31, P-33, P-35, P-11
Cough and weight loss – worried she had TB	Did not attend	RSTP-O
Toothache	3 weeks	P-3
Injecting heroin into groin while rough sleeping	Did not attend for methadone.	RSTP-K, RSTP-L, RSTP-P, RSTP-Q
HIV	Did not attend	P-12

### **Defaulting from treatment prior to completion. (33 Sources/78 references)**

Many participants reported defaulting prior to completion of treatment. Some were inpatients in hospital and left before the condition for which they were admitted resolved. CapP-G had pneumonia and did not know where to go so she let it get very bad over a week and ended up in hospital for five days - she left this early as she did not like getting IV antibiotics. P-20: *‘They were going to get me a bed but I decided on me own..... I didn’t have the time; I needed a drink so...’* (he left)

Many participants reported defaulting from treatment by missing hospital appointments which were not re-organised. FG1P-F: *‘you wouldn’t have much organisational skills or time keeping or any of them things that a normal person would just take for granted..All those appointments about your health, you really don’t prioritise that.’*

Below is the range of specific conditions referred to by some of the participants who reported missing hospital appointments.

<b>Table 5.2:</b> Conditions where participants defaulted from treatment.		
<b>Condition &amp; Treatment</b>	<b>How long defaulted.</b>	<b>Respondent</b>
HIV – Antiretro-viral medication.	4–9 months	RSTP-1, P-11, P-15, P-16, P-18, P-19, McVP-J
IV Drug Use - Methadone		RSTP-V, P-6, P-9
Pneumonia – IV antibiotics		CapP-G, FG2P-H
Hepatitis C – Antiviral medication	10 – 20 years	RSTP-V, CapP-H, P-13, CapP-I, P-22, P-25, P-5, P-29, P-32, P-36, P-38, P-14, P-8
Leg Ulcer – Dressings	4 months	P-1
Rheumatoid Arthritis OPD		CapP-J
Respiratory OPD		CapP-K
Diabetes		FG1P-E
Neurology OPD		CapP-L

I encountered a number of people with blood borne virus infections (HIV and Hepatitis C) who had defaulted from treatment. Seven participants reported not attending for HIV treatment, one of whom had not been taking medication for 4 months and another 7 months. P-18: *‘I did stop because the treatment..(for HIV).. they were giving me was making me very sick.’*

Fourteen participants reported losing out on the opportunity for treatment of their hepatitis C due to defaulting from appointments. P-22: *‘Cause I was so busy getting drunk that I missed all me liver appointments and stuff like that. And now me liver is totally in bits.’*

Participants also frequently reported leaving the Emergency Department prior to either being seen or prior to completion of assessment and management. P-3: *‘Drunk one night and I must have hit my head against something, but I ....if I had....I’d to have 4 stitches or 4 staples and I just left....I had left the hospital and it closed up.’*



**Low (often described as inappropriate) usage of Primary Care Services. (22 sources/50 references)**

As outlined in the literature review, homeless people tend to be low users of primary care services.[23, 92] RSTP-T had a severely red, swollen eye (which as a doctor I knew to be orbital cellulitis, a medical emergency). He had waited to see the mobile outreach clinic for 2 days as he had no access to a GP.' P-11 had not seen: *'a GP in years'*.

Most people said they did not attend their GP as they had no medical card. P-22: *'Cause some people would be too busy either getting stoned or drugged.....to actually send off these forms, you know what I mean. So basically they're leaving themselves without a medical card.'*

However, even the possession of a medical card did not guarantee the patient would attend the GP. P-8: *'No one to make an appointment. It's laziness. Just laziness. You know laziness and a drug addict.'*

Nor did having a medical card guarantee they would not visit the Emergency Department for primary care. P-7 explained why he used the ED: *"Eh....the only time I went to my GP was just to get the medical card...I didn't want to go to him because...anyone in my family or anything, they'd just go to A&E like so it was just kind of like, picking off where other people left off"*

**High (often described as inappropriate) usage of Emergency Departments.**

Again, as described in the literature, participants described situations where they used the ED in a manner that would be described by Health Planners as inappropriate.

Firstly, they described using it for complaints that planners describe as being more suitable for primary care services (9 sources/14 references). RSTP-E had not been able to access health care except for the ED... as he had no medical card and did not know how to get one.

Secondly, they described using the ED purely for shelter and not for medical attention.(5 sources/13 references) P-12: *"I slept there for three months (laughs)...When I went in to*

*the toilet I'd lock the cubicle, put me sleeping bag out and went to sleep...And why Casualty. What.....It's Safe... and it's warm, and it's in out of the cold".*

### **Poor compliance with medication (10 sources/30 references).**

A number of participants reported not complying with (what would seem to be essential) medication. CapP-M was supposed to be on aspirin as he had a history of having a stroke, but had not been able to collect in a few months'. P-48: *"I just stopped it (medicine for epilepsy) you know... I'd thinks I'm grand, you know...you're on top of the world again .. you think it's gone...you'd be alright for a month or two ye know"* ..(when he would have a seizure).

A few reported not taking their triple therapy for HIV. P-12: *"No, so I was thinking what's the point?"*

### **Avoidance of Psychiatric Services. (10 sources/ 17 references)**

A number of participants who had mental health diagnoses reported avoiding attending their psychiatrist or avoiding taking their psychiatric medication. RSTP-X had an eating disorder, OCD and suffered from panic attacks. She was living in temporary accommodation in a bed and breakfast. I met her through one of the keyworkers who had managed through perseverance to develop a relationship with her. She initially did not want to talk to me but after her keyworker persuaded her, she allowed me in to her small bedsit. Her physical appearance was very frail, malnourished and dishevelled looking. Her keyworker told her I was doing research but that also I was a doctor. She was very wary of me being a doctor. She stated she had a long history of struggling with an eating disorder and had many interventions from mental health services; the last hospital admission in July 2011, which she described as a very negative and traumatic experience. She did not want to see a psychiatrist as they had admitted her against her will on several occasions and she did not trust them. She had refused several attempts by her keyworker to link her with local GPs, mental health services and public health nurses.<sup>11</sup>

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<sup>11</sup> RSTP-X was not connected with any services. I left my role as researcher and tried to develop a relationship with her. I tried to get several local services to attend her including GP s and hospital services. She refused to attend and they did not take her on. She started to eat again but sadly was found dead three months later. I was still attending her at the time..

RSTP-Y had slept rough for over 15 years in a park in a wealthy Dublin suburb. He had been a successful lawyer when he developed a mental illness and was hospitalised against his will. He called it incarceration. He had not attended any doctor in those 15 years and was very suspicious when he discovered I was a doctor. He said he would never see a psychiatrist again.

In summary, homeless people in this study had several HSU behaviours that differed from the housed population and which had significant potential to harm their health. In the next chapter we will identify a number of generative mechanisms that were identified as producing this HSU tendency.

## **CHAPTER 6: GENERATIVE MECHANISMS FOR HOMELESS PEOPLE'S HEALTH SERVICE UTILIZATION IN DUB LIN.**

In this chapter I will outline what I identified as the key generative mechanisms for the HSU behaviour tendencies of the participants in this study. I use the term tendencies, firstly, as this is how critical realists describe the effect of generative mechanisms. Secondly, it is the appropriate term in that not every participant's behaviour was consistent with the HSU which I described in Chapter 4. Some of the mechanisms I identified took effect prior to the participant becoming homeless, whereas others took place during or after they became homeless. Some of these mechanisms had direct effects on the HSU of homeless people, while others had more downstream effects through the creation of external barriers, deterrents or promoters, or internalised inhibitors or promoters. As outlined in Chapter 4 I have illustrated the connections between generative mechanisms and the more downstream factors. Fig 6.1 outlines the colour code for the figures in this chapter.



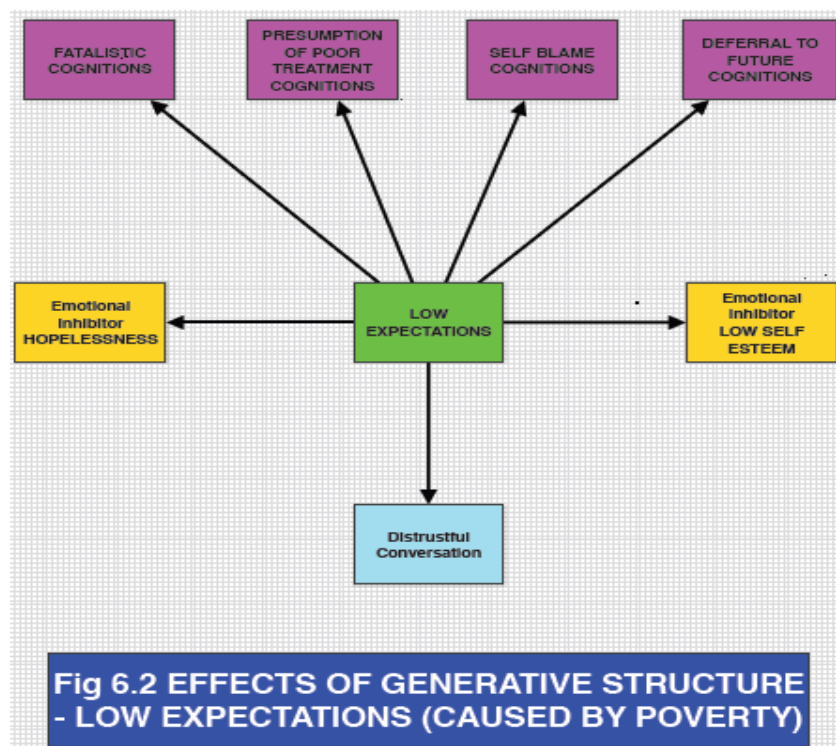
### **GENERATIVE MECHANISMS THAT PRECEDE HOMELESSNESS**

#### **1. Poverty**

The origins of an explanation for participants' HSU start well before they become homeless. Homelessness is just the far end of the spectrum of poverty and poverty is intimately associated with homelessness.[117] The vast majority of the homeless people I

encountered originated from the deprived areas of Dublin (the inner city social housing flats of the inner city and the large social housing estates from the suburbs).

(i) **Low Expectations.** ( sources/ references).<sup>12</sup>



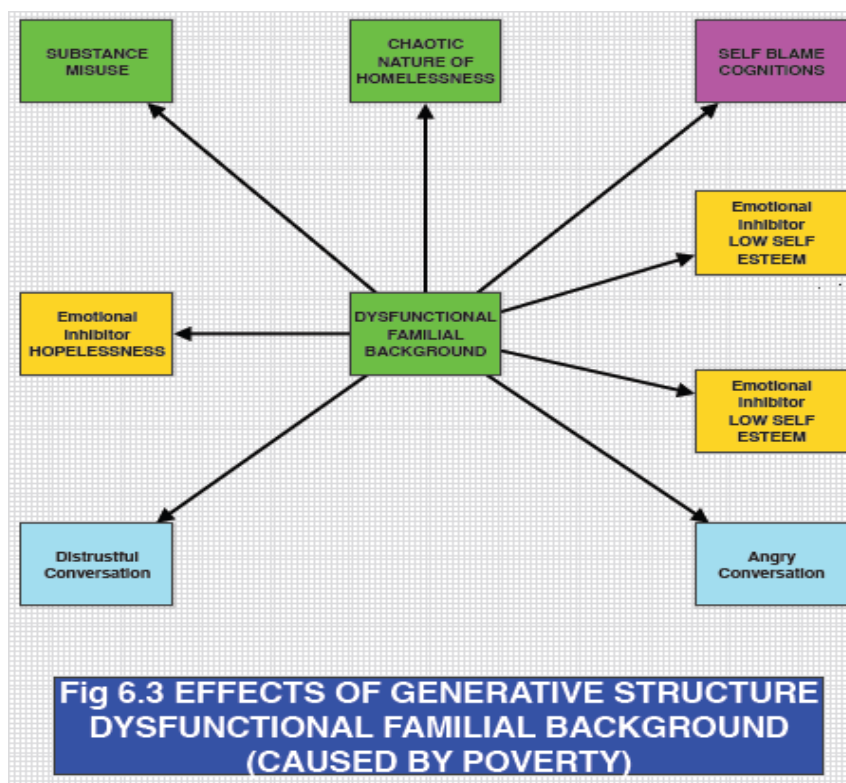
People from an impoverished background have lower expectations of what they can achieve in life.[407-409] These expectations in turn generate low expectations for health and increase the likelihood of engaging in unhealthy behaviours.[410-412] P-7 described how, when in the care of a stable family, his expectations for a better life equipped him to come off drugs and alcohol and to escape homelessness by : *“I just knew I was destined for better things.”* He compared himself to his two brothers and sister who had not being inculcated with expectations and who all used drugs, drank excessively and were rough sleeping. Such lower expectations contribute to the cognitive and emotional inhibitors affecting participants’ HSU.

(ii) **Familial Dysfunction.** ( sources/ references).

Poverty creates huge stress for families thus increasing the likelihood of those families becoming dysfunctional.[373, 413-415] Many homeless people originate from dysfunctional familial backgrounds.[242] Participants recounted stories of familial

<sup>12</sup> Note rationale for including number of sources and references in Methodology Chapter P.78

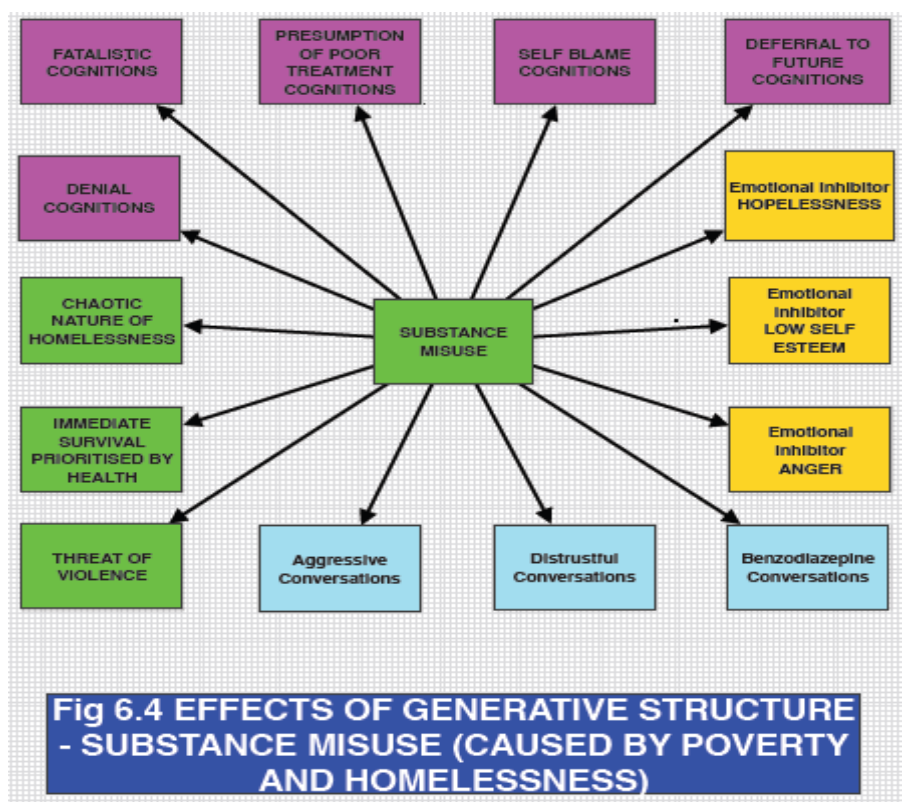
breakdown, domestic violence, parental drug and alcohol misuse, physical and sexual abuse (23 sources/71 references). P-5: “(My dad died of) *the virus*... when I was 7 though, my ma died when I was 18 months (of an overdose)...then my stepfather took me and then they got....divorced and then.... my step ma went on heroin so....my stepfather...started abusing me.” Dysfunctional familial backgrounds have been recognised as a cause of poor engagement with health services.[416-417]



Familial dysfunction often results in participants ending up in care. Almost one third of homeless Irish people have been in care.[23, 417] For some (as with P-7) this was positive, but for most, the experience was traumatic and contributed to them developing a chaotic lifestyle. P-27: “*I’m in Care since I’m six. Me Mammy...wanted to go away with her partner and he abused me...and hit me as well. He still beats me Mam... She brought me in to the Social Worker, and she left me suitcase there and then she left a note at the counter...I started going on the mitch...I was in and out of Foster Families and I was kind of being tossed from here to there...I was taking LSD all the time, because a dealer used to live in the house, and he was in his forties and there was hash...I used to snort Coke and then.....they were trying to get me to take Heroin...probably one of the worse upbringings*”.

(iii) **Substance Misuse.** ( sources/ references).

Substance misuse is endemic in areas of deprivation.[23 418-420] Participants confirmed that substance misuse was pervasive in areas of poverty in Dublin. P-41: “*You could meet a normal Dublin lad or Dublin girl and she’d know exactly where to go and what to get.*”

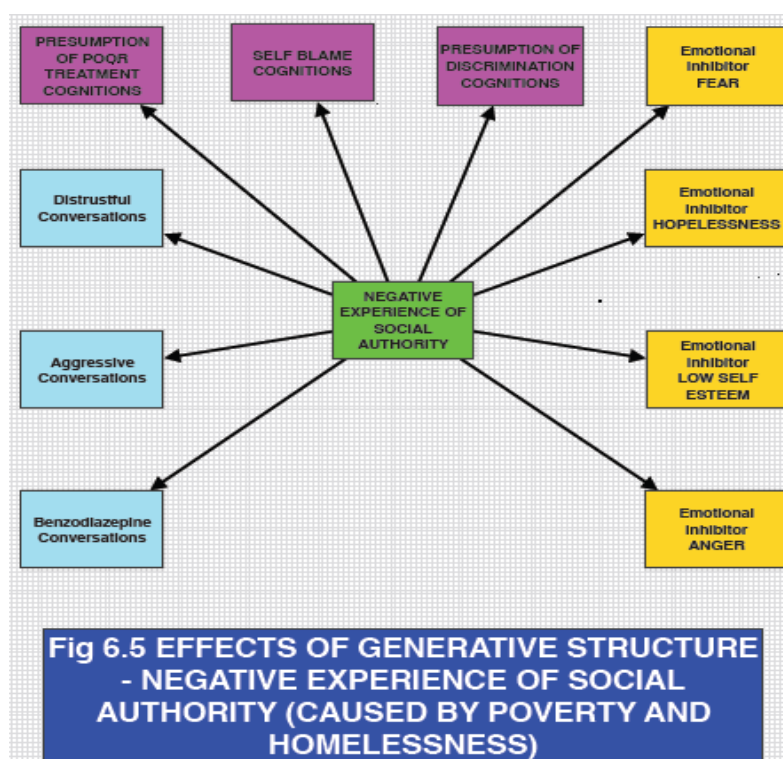


As in the literature, many participants were using drugs prior to becoming homeless.[61, 93, 421-423] P-27: “*So I was in care and I’d actually, for once, been stable in the house, because me Mam’s partner is always in and out of mad homes and he used to have these – ‘Duck Eggs’ they’re called by drug users...I was asleep for two days (laughs). That’s when I kind of got sucked into the tablets.*”

There were clear associations between dysfunctional backgrounds and drug misuse.[418] FG1P-C described how both of her parents were drug users and her mother had introduced her to drugs when she was a pre-teen. Her mother then died from HIV when she was a teenager and then she became pregnant when she was 17.

Substance misusers are less likely to engage with health services due to the chaos created in their lives by the addiction.[108, 174, 419, 424] Sadly, health services are also unlikely to seek engagement with homeless substance misusers with many even refusing to accept them as patients.[53, 147, 425]

(iv) **Fear/Mistrust of Authority. ( sources/ references).**



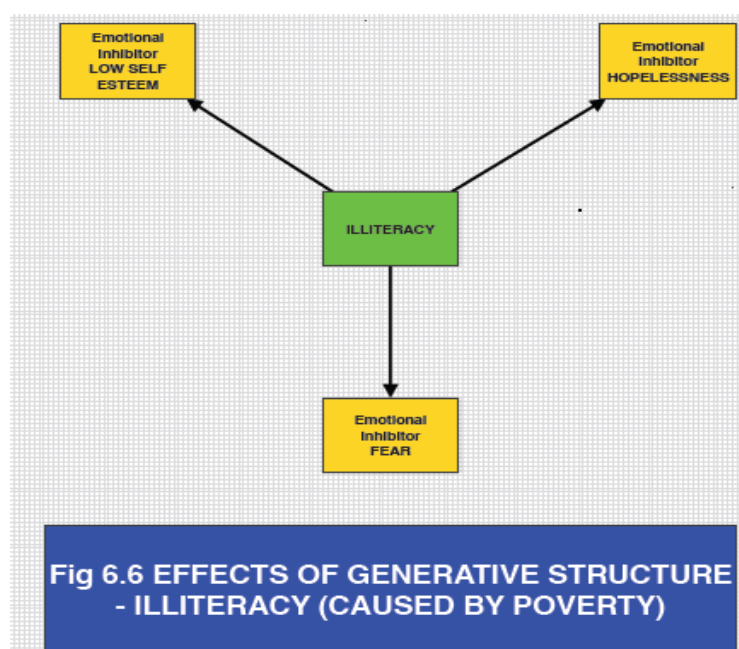
In the literature on poverty and homelessness, fear or distrust of authority figures is a well recognised reason for homeless people avoiding consulting health professionals.[92,108, 122, 164] Negative experiences of the justice system, housing authorities and of having children put in care have been noted to inhibit engagement with health services.[174, 426-427] This was evident in this study (35 sources/70 references). Many participants had experienced being in prison, usually on repeated occasions (14 sources/18 references) where their experience of authority figures was very negative. P28: *“Most of me violence was in prison. I spent...from the age of fourteen up till I was thirty three/thirty four. Yeah. I’d be only out for a week and I’d be back in. The sentences got longer and longer, you know...the screws loved to taunt me and all that.....they’d pick fights...I turned my aggression on the screws.”*

Social workers evoked much distrust amongst participants. The frequent stories of children being put into childcare were heart-wrenching. (15 sources/27 references). P-19’s ex-



girlfriend had committed suicide: *“She couldn’t take it ‘cause I was locked up. The kids were taken away from her.”* P-34 felt it was ironic that young social workers were given this power over them: *“That’s what I hate as well. The social worker...and coming in and telling you what to do with your kids. I hate that and they’ve no kids themselves.”* The irony and tragedy was that many of those who were having their children put in care had themselves had very negative memories of being in care themselves.

(v) **Illiteracy.** ( sources/ references).



Lastly, poverty and homelessness are associated with high rates of illiteracy.[428] Illiteracy affects HSU.[429-432] This was the case for some participants (4 sources/4 references). P-13 told of how he had disengaged from his Hepatology clinic. Due to illiteracy he never checked his post and missed his clinic appointment. One of the RST keyworkers made a medical appointment for RSTP-1A who missed it as he could not read texts.

**2. Mental Illness** ( sources/ references).

Mental illness both causes homelessness and acts as a deterrent for engagement with health services.[174] Homeless people with mental health problems have themselves identified a similar range of barriers and deterrents to usage of health services including competing priorities; lack of information; lack of finance; waiting times; previous bad experiences with health care providers and previous experiences of being denied services.[53, 164,

425] In this study a number of homeless people with mental health problems refused to engage with health services.

RSTP--M slept in a doorway for over three years. He had a flowing white beard and wore typical tramp clothing with several coats and a tweed hat. He told everyone who approached him including me to fuck off. The only service he engaged with was to go for his dinner to a local food hall. We brought a psychiatrist to see him who could not do an assessment as he refused to engage. He was admitted to a hospital eventually where he was diagnosed with schizophrenia 8 days before he died.<sup>13</sup> P-49 would not engage with any doctor as he had been compulsorily admitted to a psychiatric institution many years earlier. He would not go to hospital as he believed the doctors would commit him to a *'fucking asylum'*.

### **3. Language (3 sources/4 references).**

Lack of interpreting services been identified as a barrier to accessing healthcare for migrant homeless people.[433] RSTP--1B told me how he had injured his shoulder in an accident and had had an x-ray in the Mater Hospital. He had not been able to get the results due to his poor English.

## **GENERATIVE MECHANISMS THAT TAKE EFFECT WHEN HOMELESS.**

I identified three generative mechanisms that affected homeless people's HSU during the time they were homeless.

### **1. The State of Homelessness**

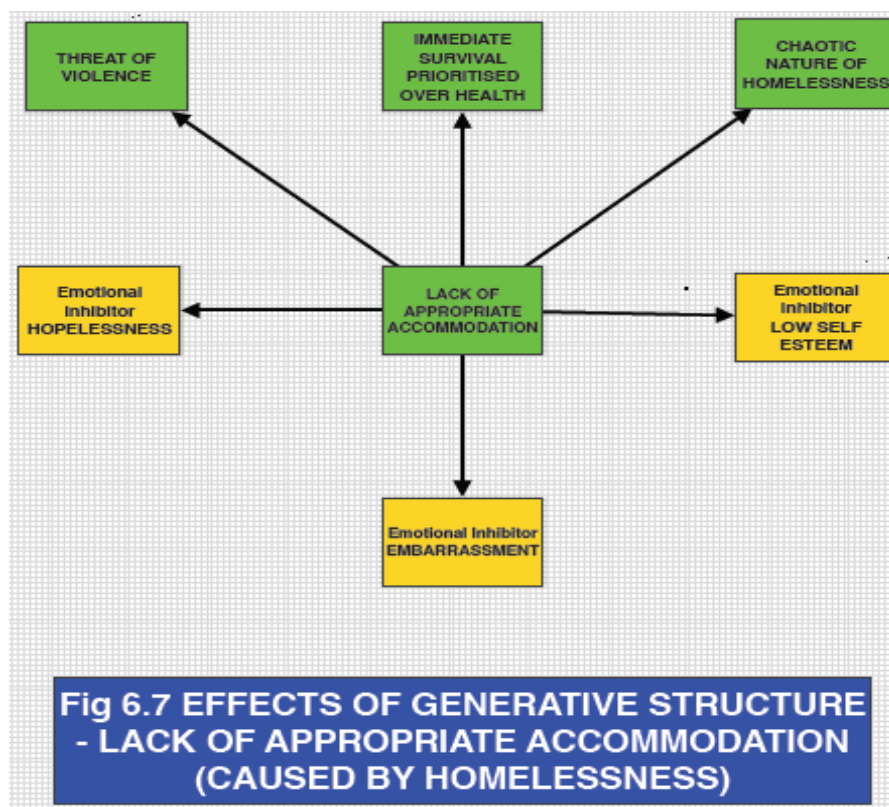
As already discussed homelessness is, in one sense, a constructed concept. However, it was evident from this study that the participants had experiences that seemed specific to their existence as 'homeless' persons. There was a reality associated with the constructed notion of homelessness that was stark and grim. This 'reality' seemed to account for a number of the factors that directly impacted on the HSU of participants in this study.

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<sup>13</sup> Addendum – I visited RSTP-M after the study a number of times as a doctor. One day I was told he had not turned up at the food-hall for three weeks due to there being a fight one lunch time. He refused to come for a medical check-up and when I asked him what would he want he agreed to go for a haircut. We brought him to a medical centre, gave him a haircut, a meal and a medical check up. He initially refused to go to hospital but when we brought him to his doorway he agreed to go in. He was admitted and died ten days later from pneumonia on top of malnutrition. This happened only one month after I had finished the study and reinforced for me the stark reality of the danger to health of being homeless.

**(i) Lack of Appropriate Accommodation affected HSU.**

In the homeless sector, the place where people spent their nights had a significant effect on their health service usage as well.(10 sources/19 references). As P-31 said: *“most of us just need a home to start us off.”*



P-1 had a chronic severe leg ulcer (covering half of both his lower legs) which, if not dressed daily, would deteriorate, become infected and incredibly smelly: *“When I wasn’t living anywhere permanent...I would miss but I’d be annoyed with myself and then I’d....then when I would go to (the nurse) and I would be a really bad...the smell .....I know for a fact by the way, it must be really diabolical on somebody else like.”*

The concept of homelessness embraces a range of accommodation statuses ranging from those sleeping rough in the streets, to those in emergency hostels and those who were couch-surfing. Each of these scenarios had effects on the HSU of participants.

Rough sleepers lived in the harshest circumstances (24 sources/55 references). P-49 had slept rough for 15 years in the park of a wealthy Georgian square in a Dublin suburb. He knew all the local residents and received meals, coffee, clothes and money from them.

When I first met him he was sleeping in an igloo that some local teenagers had built in the park. He was lying in the snow and could not get up. He told myself and OW1 from the RST to fuck off when we approached. We went a little distance away and approached again a few minutes later. He told us to fuck off again. After three times of us withdrawing and re approaching he accepted our help. He had been diagnosed with schizophrenia not long after qualifying as a lawyer. He had a spinal deformity and was bent over. His clothes stank of urine and faeces. He said he had not changed them in 3 weeks. He collapsed twice when we were there. He had no medical card and had not seen a GP, nurse or hospital doctor in several years. P-1 also described the harshness of rough sleeping: *“When I first became homeless? You’d wait for the night bus...(to bring you to a hostel)...and they’d say that they’d come back and sometimes they wouldn’t come back...and you’d be left there with no sleeping bag, with just the clothes that you’re standing up in...I have rheumatism from lying on cold concrete...you’d find bundles and bundles of cardboard ...to lie on or put over you...you can’t find it, or it’s wet ...You’re actually sleeping with your runners under your jacket ...you’re afraid to go into a heavy sleep in case somebody robs your dole card...because you have...put it this way, your life on you? Your life is in your pockets.”*

It was clear that in a rough sleeping environment the maintenance of health dropped down the priority list. Neither P-48 nor P-49 had a medical card or a GP and never attended hospital. RSTP-F missed hospital appointments when rough sleeping and her rheumatoid arthritis had caused irreparable damage. Rough sleeping meant that participants could not wash or clean themselves. RSTP--E who had slept rough for 27 years was wary of going into doctors’ surgeries as he would feel self-conscious of his appearance and possible smell and was also intimidated by crowds.<sup>14</sup>

The presumption that a hostel would be better than rough sleeping was often refuted by participants who chose not to stay in hostels (21 sources/34 references). P-6 said the

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<sup>14</sup> The harshness of rough sleeping presented a dilemma for me as I had developed relationships with these rough sleepers who had severe health problems that were untreated. I found myself intervening with a number of them successfully. OW1 and I spent two days trying to persuade P-49 (whom we felt was at huge risk during the icy weather of dying from exposure) to go into hospital. After spending one month in hospital he was sent to a hostel. He caused huge difficulty by smearing his faeces on the walls of the hostel room every night and urinating on the floor. I visited him a number of times in the hostel and though he continuously gave out about the hostel, he never asked to leave and would return every evening to gain readmission. I persuaded RSTP-F and her partner to go on methadone and an alcohol detox. They both became totally clean off heroin and alcohol and have been staying in their own accommodation for over 6 months.

hostels he was offered were always dangerous and poorly run: *“I’d rather be found dead in the street than in a hostel to be honest with you.”*

There was a wide variation in hostel accommodations which ranged from new modern buildings with well kept common areas and single rooms, to run down old buildings, with large dormitories and disinterested staff. P-23 described how it was easier to keep appointments when staying in a well-kept hostel. *“I was in (Hostel B) and I was just using and using and using.....didn’t give a shit about anything or anybody, you know. The place was crazy.....drugs all over the place. Over here it’s different, it’s spotless clean, you know what I mean. You’ve Case Workers to help you out. It’s a phenomenal place, you know what I mean. You get a lot more respect from the staff and from people here. You’re treated properly, you know and it’s easier to get your appointments going, to start the ball rolling again.”*

Participants referred to how hostels often failed to take account of their medical needs. RSTP--G was in severe pain from sciatica and had to use crutches. She broke down in tears when describing how she had gone to the ED and was told to have bed rest but she had to leave hostel from 9.30 to 16.00. She spent her day-time hours in a library in pain

HSU in hostels varied depending firstly on whether there was a GP specialised service attending the hostel and secondly, on how interested and active the hostel staff were in engaging with and encouraging participants to attend their doctors both for addressing immediate needs and for follow-up appointments

A number of participants couch-surfed. Couch-surfing was a tenuous existence where participants had to ensure they did not overstay their welcome. It usually meant participants became disengaged from their own GP, while also not being able to avail of specialised services present in hostels or the aid of keyworkers to engage them with health services.

Participants faced a number of administrative barriers to accommodation which also impacted their HSU (5 sources/8 references). Participants from outside Dublin could only obtain accommodation from night to night as the City Council wanted to deter people who have become homeless from ending up in Dublin. RSTP--H moved to Dublin from the

country as relationships with his family had broken down and he had developed a drug problem and could get no treatment in his home town. He survived night to night by staying in emergency hostels or rough sleeping. In both scenarios he was surrounded by drug use and violence and, despite being on methadone, could not get clean off heroin. He found it difficult to access health services as his day-to-day life was so chaotic. RSTP--K and RSTP--L had been staying in Dublin for 8 to 10 month. They had been told they were not entitled to social welfare or accommodation. Both were using heroin and were groin injecting and neither had medical cards.

According to its administrative rules, Supported Temporary Accommodation (STA) can only provide accommodation for a maximum of six months. The aim is that after six months one will have secured more long term accommodation. However, the setting up of STA's coincided with shortage of rental properties being available so many people could not get accommodation. Their routine, including attending health services, was further thrown in chaos by losing their accommodation. CapP-C was evicted after 6 months. She had stayed the previous night with a man she had met in the food hall the previous day thereby exposing herself to potential danger. She had missed her methadone as she had been in the social welfare office because her welfare had been stopped due to her homelessness. She had no idea where to go for the afternoon. She had gone from regularity to chaos.

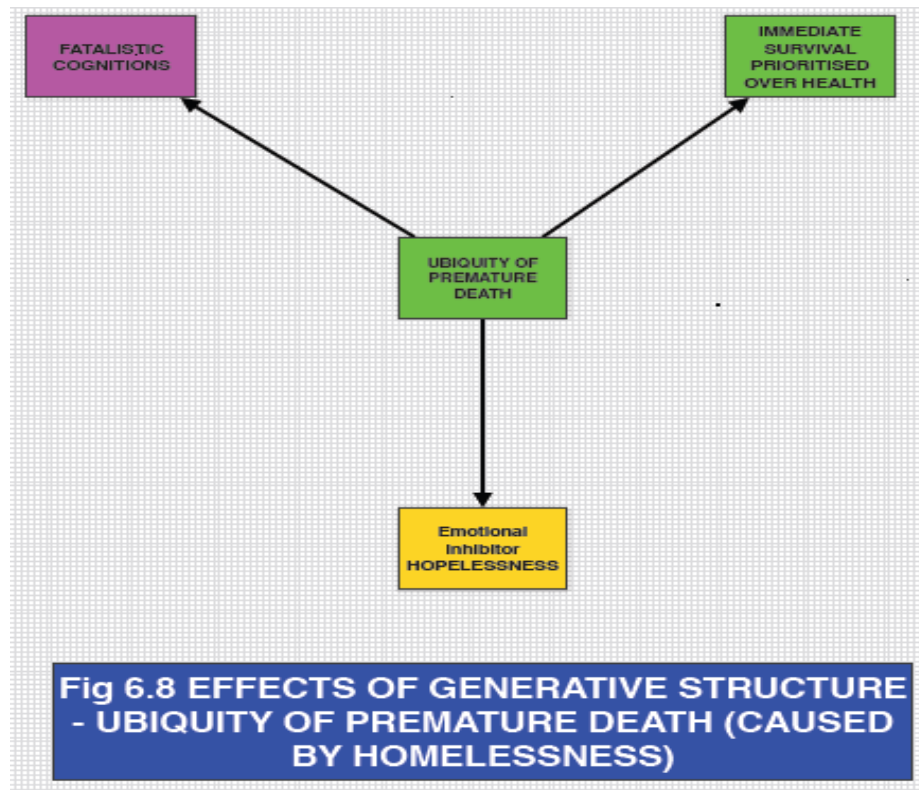
Administrative glitches and bureaucratic rigidity also created barriers to HSU. RSTP--J had been renting for a whole year. However, he lost his accommodation and then went to the Council looking for accommodation. *"They couldn't find my files in the Dublin City Council.....they couldn't house me and I went back to the streets."* The idea that one could not be housed due to the loss of a file seems implausible. But, what might appear to a housed individual as an administrative blunder will actually act as a total barrier to the homeless person with fewer assertiveness skills or less confidence in the system's ability to rectify its mistakes.

Another administrative barrier was created by the 'Freephone'. This is a free number which homeless people ring and are told which hostel to go to and at what time to turn up. When working with the RST I came across several instances where the Freephone left participants with no choice but to sleep out. The RST told me of a woman discharged from

the Rotunda obstetric hospital after having a miscarriage and when she rang for a bed and was told that there was no bed available. The RST had found her three hours later feeling weak and also with blood stained trousers. I have often seen participants refuse accommodation in certain hostels due to fear of violence. They were never offered alternative hostels. Furthermore, the manner in which participants were spoken to was on occasions abusive. RSTP--D (a young man) was sitting down outside Island House hostel with a bag of gear. I noted him sitting patiently for a good half hour as I walked in and out of Island House. He had a traveller accent. He said he was pissed off waiting – he had been there for an hour. He had been told by the Freephone to go to Island House, that there would be a bed at ten thirty. Island House reported not having been informed that he was to get the bed, so they asked him to wait outside. He told me his brother had committed suicide by hanging three weeks previously. One of the Dublin Simon Rough Sleeper Team had just phoned up the Freephone for an update. He then rang the Freephone himself again and he started saying on the phone “I didn’t ask them to ring.” He told me as he held his hand over the phone: *“they are giving out to me saying I should not have got the RST to ring in on his behalf”*. He was very angry. I felt angry as it was entirely appropriate for the RST to ring in. He then talked again and I heard him say: *“I amn’t barred”*. He then let me listen and said they had said to him (in a sarcastic tone): *“we hope you are not barred.”*

**(ii) Ubiquity of Premature Death affected attitude to HSU.** (17 sources/39 references).

For homeless people, death is ubiquitous and could always be just round the corner.[54] I encountered three people who died during the course of the research. RSTP--M died after spending two weeks without eating. He stopped attending the food hall he had always frequented following a violent incident (not involving him). RSTP-N had returned to his hostel very drunk. He was put in the TV room and fell. He was sent to the ED, but he left and came back to hostel. He went to TV room and was later found dead. P-19 committed suicide while I was writing up the thesis. Each week there were stories circulating about new recent deaths. P-13 described how his best friend had just hanged himself in prison. He added that 4 other people died that same week, one from snow-blow (colloquial term for illicit drug mehtadrone), and 3 others had collapsed, but no cause had yet been identified. His opinion was they had probably overdosed.



A number of participants had experienced losing their parents to drug related death. P-11: *“My Mother only died last November of Emphysema and HIV...You know and the Crack killed her in the end. With the Emphysema, you know...Me Auntie, me Uncle...died of HIV...After his Mother died he OD’d.”*

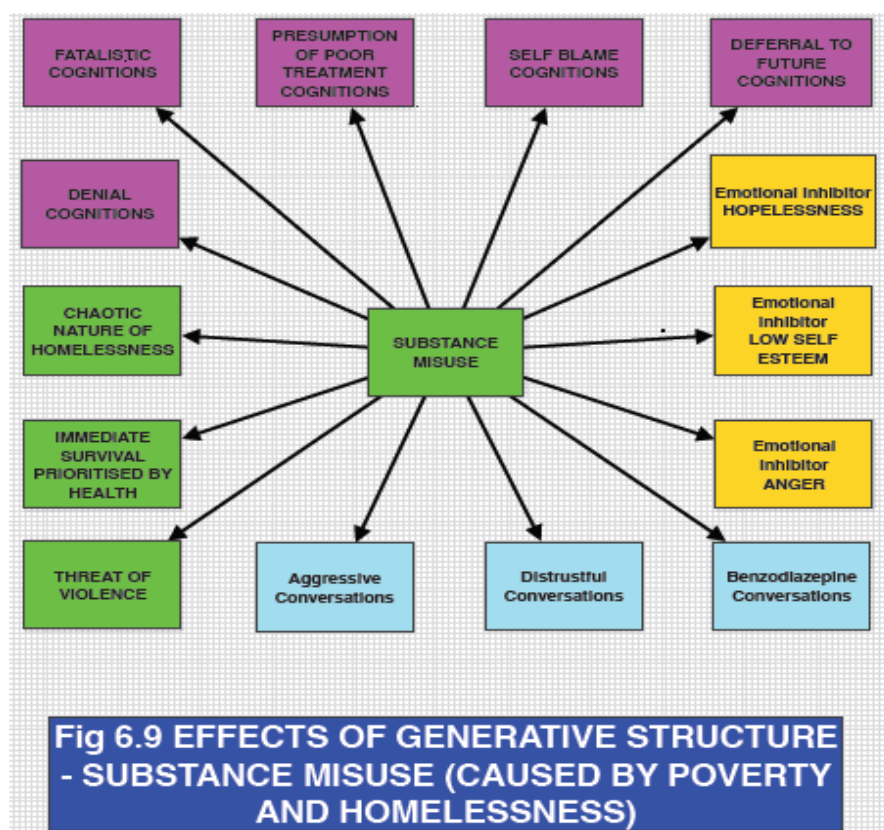
**(iii) Substance Misuse was endemic and affected HSU (42 sources/107 references).**

Substance misuse is pervasive both in areas of poverty and in the homeless population being both a cause and a consequence of homelessness.[53, 308, 421-423, 434] P-41: *“I can walk down and get anything I like, do you know what I mean. Within seconds”* It did seem that homelessness had a ‘concentrating effect on the effect of drug misuse. P-9: *“When you’re in the hostels (drug misuse is) always in your face like.”*

Alcohol misuse is pervasive in homelessness.[435] It is often the trigger for many participants becoming homeless. P-7: *“Then I started drinking heavily and then not paying rent and then just one thing led to another and then back on the streets.”*



Many participants were co-addicted to alcohol and drugs. P-20: *“But it still doesn’t mean that I’m comfortable sitting there like and I suppose like.....the drink.....it’s a catch 22.....like the drink and the drugs help you sitting there.”*



The use of drugs affected the health of many of the participants (16 sources/23 references). RSTP--B was injecting into a groin abscess and his partner RSTP-A was injecting as well into her groin despite having a history of sub-acute bacterial endo-carditis. RSTP-I was injecting into a large vein in his groin despite the fact and he was on an anti-coagulant medication for a history of blood clots;

Being on drugs, meant that the participants stopped caring for their personal hygiene. P-20: *“When I do take drugs I don’t take care of myself. I don’t wash myself, you know, I’d be sitting in the waiting room and I’d be smelly.”*

Alcohol also affected participants’ health. P-15: *“He said ‘my God, you should have been dead years ago’. Because I was a chronic alcoholic.”* P-11: *“I was a chronic alcoholic... I’ve Cirrhosis of the Liver...I took two mild strokes without taking a Librium and I went*

*into an 'Awake Coma'...My stomach swells out bad. I get very sick and tired...I get drained."*

It is known that substance mis-users are less likely to engage with health services, often due to the chaos created in their lives by the addiction.[91, 174, 419] The procurement of drugs and/or alcohol was often prioritised over HSU (15 sources/33 references). RSTP--K was unkempt and emaciated. He had several drug abscesses. He said he had not visited the doctor as he was *"too busy surviving being homeless."* He said when using drugs: *"you don't give a fuck about your health - all you want is the drugs."* FGP-C made similar comments: *"I suppose when you're so bad on drugs, you just don't care about it. You have no routine in your life. You have no organisation in your life plus you're very forgetful. Also because you're out of it most of the time and if you're not, you're dog sick. So, one, you don't really have a lot of respect for yourself and you wouldn't have much organisational skills or time keeping or any of them things that a normal person would just take for granted. To go to appointments and to be on time and stuff like that."*

FGP-E, a female diabetic gave a vivid description of how she sacrificed caring for her health for drugs: *"I'm a diabetic since I was 8. I'm a heroin addict since I'm 22. So for the last 6 years, I've never kept an appointment and the only time I've been to hospital was when I had to go to A&E because my blood sugar was so high. I just never looked after my diabetes when I was on drugs. As soon as I was on drugs, my blood sugars, I'd be dehydrating, tired, eat whatever and then putting insulin into me and then probably drink a bottle of coke just to make sure I wouldn't go low when I was high. I didn't care. All I cared about was my drug. I never did blood sugars. I didn't care about keeping appointments."*

Misuse interfered with users' ability to obtain a medical card. P-22 commented that many homeless drug-users never applied for a card: *"cause some people would be too busy either getting stoned or drugged.....to actually send off these forms, you know what I mean. So basically they're leaving themselves without a medical card."*

Ironically it is recognised that substance misusers are often too busy getting drugs to spare time to seek treatment for their addiction.[108, 424] RSTP-P was addicted to drugs and wanted methadone treatment. He had heard that there was a doctor who visited his hostel

who dispensed methadone, but had not been able to visit him as he was busy during the day time getting drugs, social welfare and going to food halls.

Many participants (9 sources/15 references) used drugs or alcohol to treat the symptoms and so avoided HSU. McVP-A took heroin to reduce the cough caused by chest infection: *“Yeah, you wouldn’t feel anything when you’re on the heroin, it’s only when you start to recover that you’d feel sick, and then what you’d do is you’d score again”*. P-1 took heroin to ease the discomfort caused by his leg ulcer: *“I’d have a shot of heroin....it would sort of ease the thought....but it wouldn’t ease the smell if you know what I mean?”* P-13 used to: *“drink more or use drugs, just forget about the sickness.”* When he had a bad flu he *“just used more Heroin and tried to get over it and that.”*

Alcohol or drugs could also block symptoms of illnesses so that the user would not be aware of their illness. P-6: *“I wouldn’t have even known I was sick cos I was just like drinking all day.”*

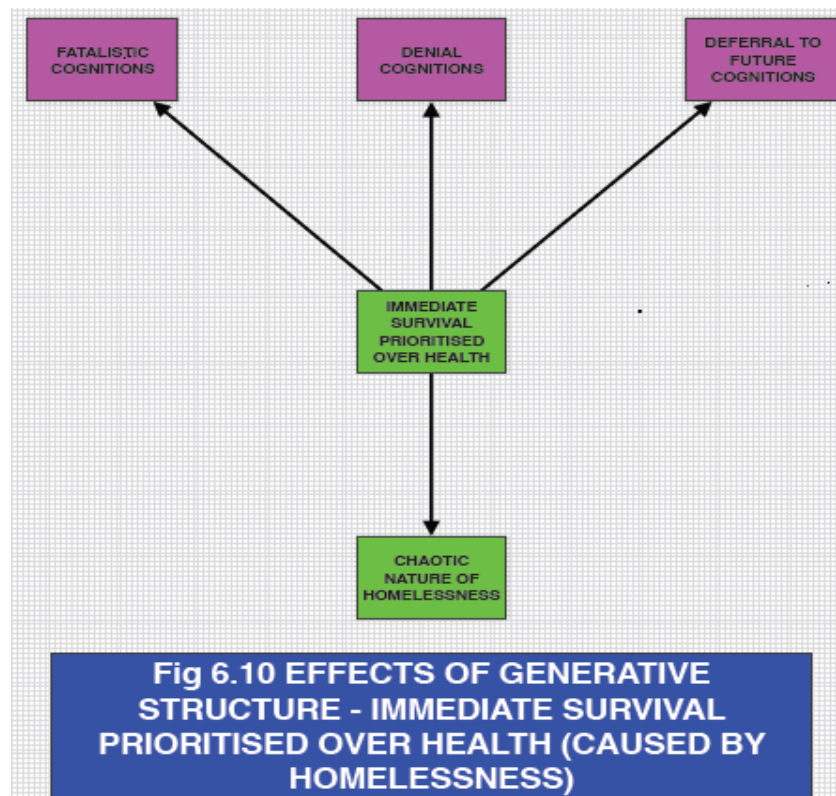
Participants also used drugs to treat mental health symptoms. P-28 smoked heroin as: *“it was keeping me calm... When I would start getting the feeling that my head was going.....I’d get a bag of gear and smoke it or bang it.....when I had veins.”*

This use of substances to treat illness deterred participants from using health services.

#### **(iv) Immediate Survival was prioritised over HSU. (35 Sources/99 references).**

Taking into account the high rates of premature death and level of violence, it is not surprising that participants said their main aim when homeless was to survive (12 sources/17 references). P-41: *“It’s holding on to the fuckin’ rope and not letting go, you know what I mean.”*

This fight to survive affects HSU as homeless people prioritise more immediate needs that they see as more important for day to day survival than health. This is referred to in the literature as competing priorities.[53, 105, 128, 147, 164] FGP-F: *You don’t prioritise yourself. All those appointments about your health, you really don’t prioritise that. It’s like, where are you going to get your next drugs, where are you going to get money. So that all comes first and the appointment doesn’t fit in, it’s just left aside.”*



These priorities included, obtaining shelter; drugs or alcohol; food; money from social welfare or tapping; or consulting social welfare officers; childcare social workers; probation worker; key workers etc.

**Accommodation: (39 sources/137 references).** Many participants detailed the daily grind required to obtain accommodation. P-27 outlined how the uncertainty of accommodation translated into an uncertainty of obtaining healthcare: *“It’s just when you don’t know where you’re going to be next...Say, if I was still in that Hostel and all of a sudden I got brought to another Hostel, I’ve to worry about where I’m going and will me prescription be there and will they understand that.”*

For people who were rough sleeping the lack of structure which could be obtained by having accommodation meant that their day was dominated by going from drop-in to food hall with very little room left for medical appointments. RSTP--F was diagnosed with rheumatoid arthritis. She was given an appointment for the outpatients but she never followed up as she was rough sleeping. The joints of her hands had become irreparably

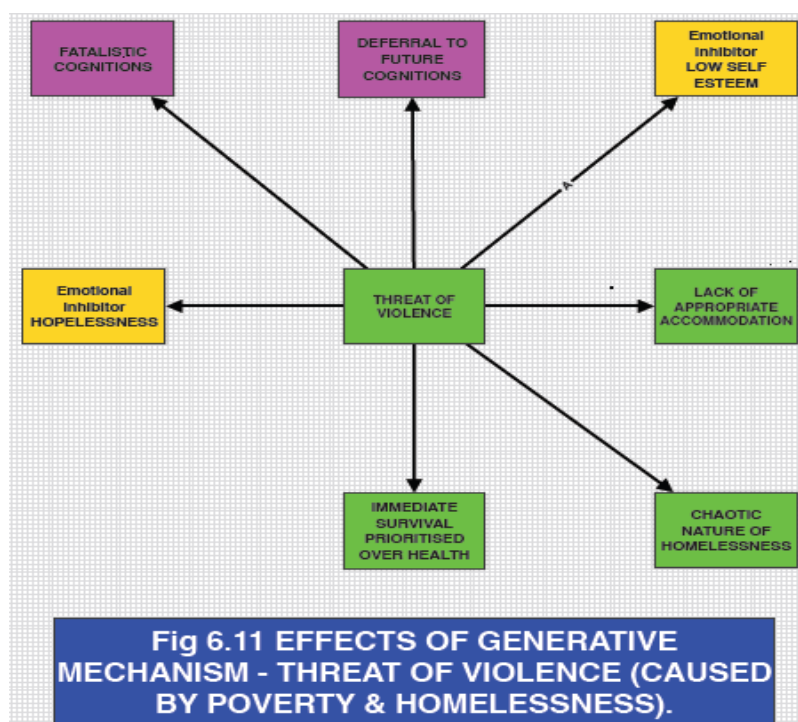
deformed. This could have been prevented had she received disease modifying drugs through the outpatients.

**Money and Welfare (19 sources/39 references):** A number of participants detailed how the need for money (often to pay for drugs or drink) led them to take actions deleterious to their health. Some sold their medication. P-15 sold his HIV medication on the black market to Africans with affected relatives at home, in order to obtain money.

Many homeless people ‘tapped’ or begged to obtain money. P-20 *“But it still doesn’t mean that I’m comfortable sitting there like and I suppose like.....the drink.....it’s a catch 22.....like the drink and the drugs help you sitting there.....then I’m sitting there to get the drink and the drugs.”*

**(v) Threat of Violence affected HSU. (26 sources/78 references)**

In homelessness violence is ubiquitous.[147, 427] Their experience of violence often precedes homelessness, starting in their family of origin.[2, 147]



A number of participants had observed violence. (7 sources/13 references) (I myself witnessed a few aggressive violent incidents.) P-48 described how he witnessed a fellow

rough sleeper die in a hostel due to an assault: *“They thought he was drunk and they said “either get out and walk it off or go to bed”...You’re not supposed to go asleep with a head injury... and he never woke up the next morning. He got a dig with a knuckle duster into the head.”*

Many participants had experienced violence (15 sources/32 references). I interviewed people who had been assaulted in the previous 24 hours on several occasions. RSTP-A outlined how violence was “to be expected” when one is homeless. She had been assaulted when sleeping rough in an old abandoned house by some local youths and hit in the face with a plank. She was still staying in the squat despite the assault. P-22 described previous assaults he had experienced: *“No except like being chopped up with a hatchet...I got me two arms broke. They smashed me hands as well. Both my hands. They also used a metal blade. I was begging and this bloke didn’t like it and he gave me a punch and I lost my first tooth.”*

Repeatedly participants reported how the level of violence encountered outside addiction treatment centres created a deterrent to HSU at those centres (18 sources/28 references). CapP-O and CapP-Q both described being bullied outside treatment centres resulting in them leaving and stopping their methadone treatment. As P-48 said: *“It’s a dangerous town at the moment .. they, they’ll grab you in a lane. The lions was watching.”*

Gender-based violence is also common in homelessness.[89, 437] A number of participants experienced such violence (5 sources/7 references). P27: *“Because it got to the stage – I was raped when I was twenty one and because I wasn’t used to tablets, apparently there was three Rohypnol put into me drink.”*

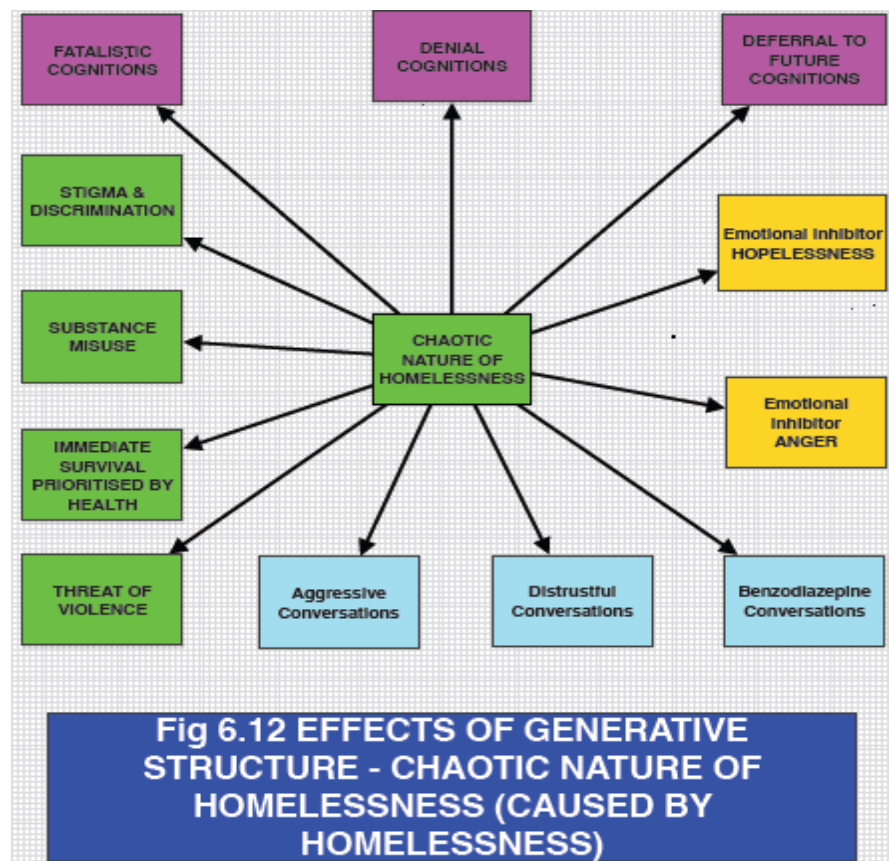
Homeless people are often perpetrators of violence.[373, 438-439] Some participants confessed to being violent. (4 sources/7 references). P-38 admitted to having: *“a tendency to violence. Most of me violence was in prison”* He went on to describe how he had assaulted a stranger he had met on the street as: *“he had annoyed me”*.

The ubiquity of aggression in homelessness inevitably arose in their relationship with health professionals negatively impacting their HSU. FG2P-G: (The doctor) *“was feeling brave because I was handcuffed to a Screw and there was another two Screws there with*

*me...she came out with that answer. And I snapped on her! I said, "I won't think twice about sticking that scissors in your head".*

Some participants talked of having to adopt an aggressive pose in order to ensure their own safety by scaring potential predators or assailants away. (5 sources/6 references) The hostel manager of the Sancta Maria Hostel which specifically sheltered non-national homeless people told me he felt non-national homeless persons acted aggressively when in other hostels as this acted as a form of protection. RSTP--M used sleep in a doorway. He would tell everyone who approached them, friend or foe, to fuck off.

**(vi) Chaotic Nature of Homelessness affected HSU. (26 sources/56 references).**



The potent mixture of a fight to survive, the pervasiveness of substance misuse, the unstable nature of accommodation and the level of aggression has contributed to the chaos that seems integral to the nature of homelessness. [440-441] P-7: *"Just drinking, doing drugs, just living in different hostels and then getting my own place and then not being able to keep it up and just going around in circles really like...when I left care like, I didn't really know how to live like a normal person...Then I started drinking heavily and then not*

*paying rent and then just one thing led to another and then back on the streets and ....back into the vicious circle like.”*

The negative effect of chaotic lifestyles on engagement with health services is particularly notable for homeless people.[442] FG1D-F: *“I suppose you feel – I know there are chaotic lifestyles and things like that. You don’t follow up with an appointment or a scan sometimes. I don’t know, it’s just hard. Maybe you don’t feel like you’re getting through to them. Here’s the importance of the scan, you have to show up. Then something happens in the mean time and they don’t show up. Then something will happen and they come back again.”*

**(vi) Negative experiences of social authority (35 sources/70 references).**

When homeless, participants had experiences with authority that often mirrored and re-enforced earlier negative experiences of authority. A number had been barred from hostels or had very negative experiences with social welfare and social work systems. CapP-E had been homeless for many years with her son. She had approached a charitable organization for money, but after being questioned about her income in what she felt was a dismissive manner she felt humiliated and during interview was visibly upset.

A number described bad experiences with authoritarian medical professionals. McVP-C described how his GP had picked up his prescription and said *“if I want I can tear this up”*. He said: *“he tore it in front of me. I said what sort of Doctor would do that”*. He described the doctor as: *“acting like God”*.

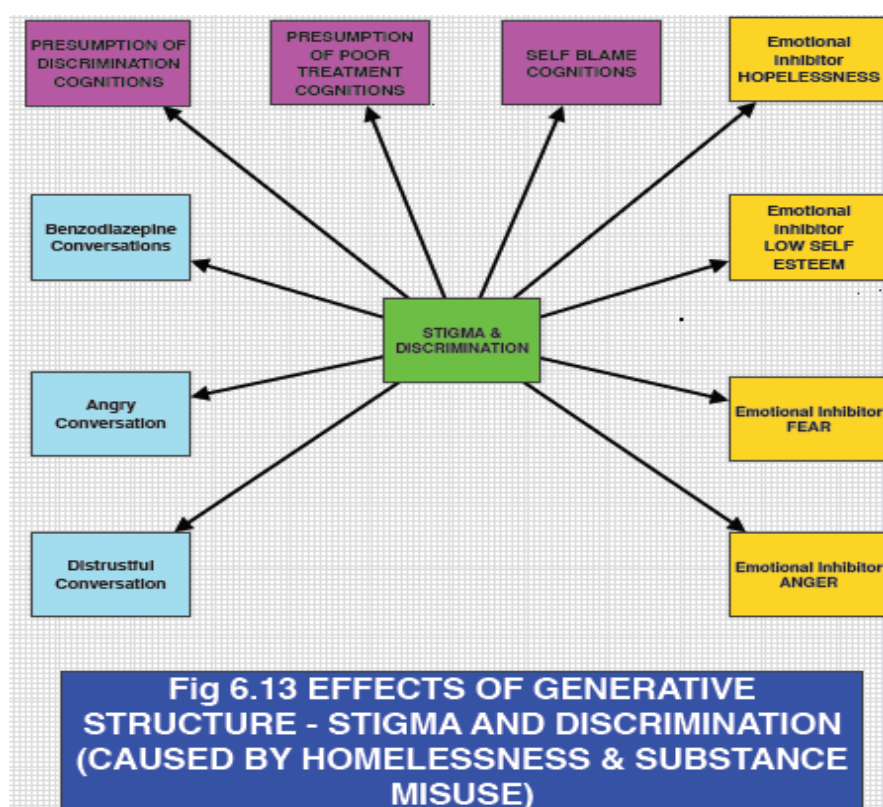
This distrust of authority had a tendency to affect participants HSU. CapP-D was a woman in her forties whose two children had been put into care when she developed a mental health problem. She said when she first moved there and her children were taken from her she made dinners every evening in case they came home. She said she was not attending her psychiatrist as she felt his interventions would make it less likely for her to get her children back.

**2. Stigma and Discrimination. (35 sources/222 references)**

Goffman(1963) proposed that stigma occurs where certain groups firstly are categorised as belonging to distinct group that share a spoiled identity.[16] It is well recognised that



homeless people face stigma and discrimination.[50, 443] Participants identified stigmatizing attitudes and discrimination as a significant and frequently encountered external deterrent to HSU. FG1D-E described how when working in hospitals: *“somebody happens to be a drug user predominantly or alcoholic ...the shutters come down, the assumption is that all their problems are to do with this.”* P-23 reflected on the same issue from the homeless drug-users perspective: *“most drug addicts think GP’s ..... if you go in with any illness as soon as they hear you’re on drugs they’re going to start looking down on them and they’re going to start talking down to them and treating them different.”*



### **3. Health Services have developed to suit the HSU of the Domiciled Population and not the HSU of Homeless People.**

It is clear that mainstream services do not meet the needs of homeless people.[173, 444] Homeless people’s HSU in particular their high use of ED and low use of primary care is appropriate from the perspective of a homeless person. ED is always open, does not require an appointment, offers shelter in the evenings, has spaces where homeless people can congregate without feeling conspicuous (e.g. outside the door in the ED) and you are likely to meet someone you know and can talk to/have a cigarette with.

Gelberg identified that mainstream health services are not designed to meet the needs of homeless people. [164] Primary care services require you to either pay or have a medical card, make appointments, have confined waiting areas, are closed in the evenings, nights and weekends, and are interested in preventative health (of low priority for homeless people as P-11 pointed out: *'see my mind is just more about drugs, drugs, drugs...I've no medical card'*). Also primary care services presume one has a home to recover in. RSTP-G broke down in tears as a doctor had advised her to rest to allow sciatica to recover but he did not realise she lived in a hostel which required her to leave at 8am in the morning and not come back till 6pm in the evening.

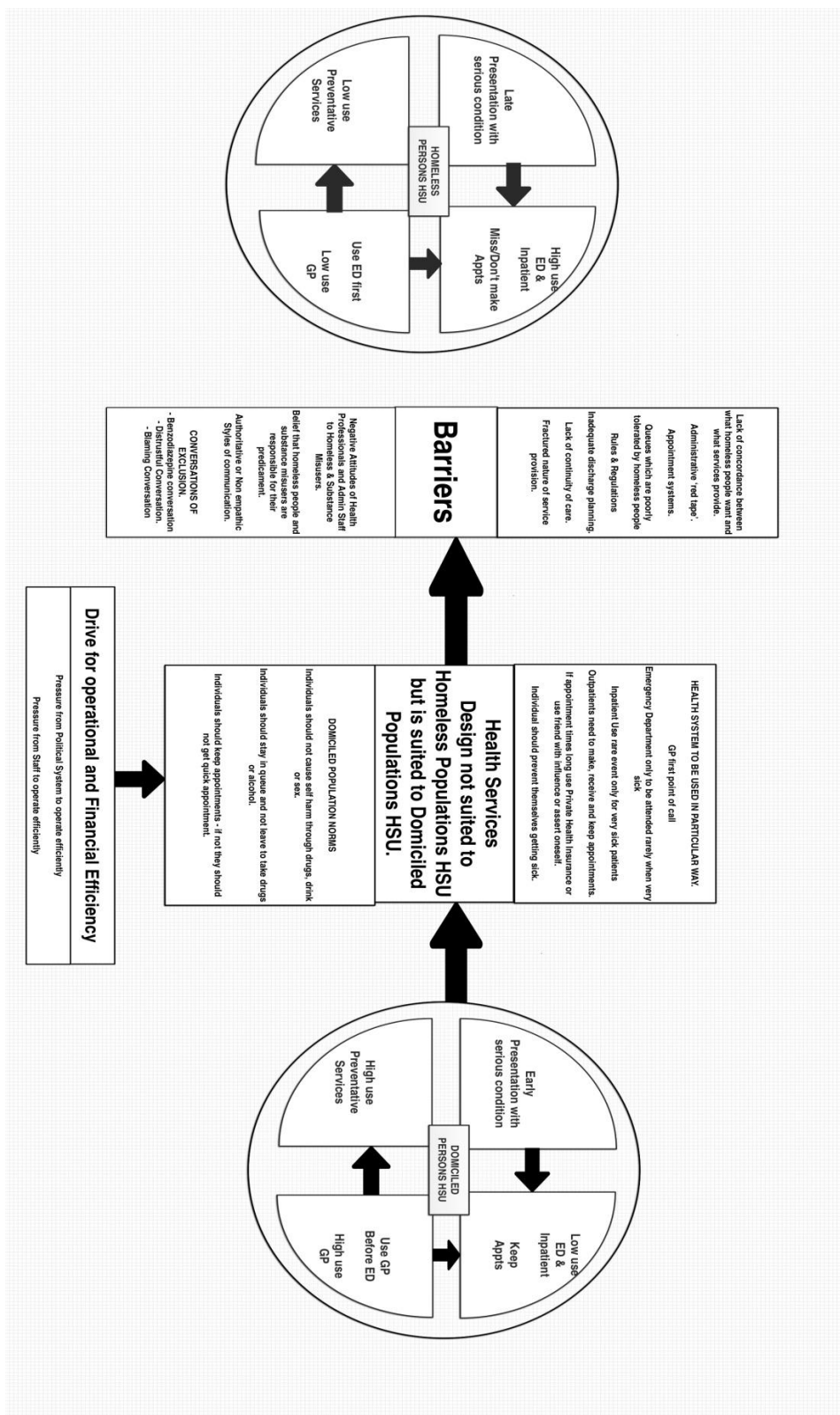
'Mainstream' service developers and providers presume that their service should be used in a particular manner which stems from a compromise between the needs of the 'mainstream' of housed people and the requirement to provide a cost efficient health-service. Thus people should consult their primary care services for both preventative health and for initial assessments of minor and/or potentially serious conditions. From there, they could go to OPD or ED where they wait their turn and are either treated or admitted. They complete their treatments and comply with all health professional advice and medication. They should also complete all administrative forms required for delivery of services e.g. medical card applications. P-44 did not have a medical card: *'I had blood poisoning...and blood clots in my leg and I actually walked around for...a week and a half because I didn't know what to do...Because I had no medical card...and I was actually afraid to go up to hospital ...And as well, I should have had it...a medical card, which is my responsibility to have, but....with the medical card, trying to get a medical card it's...how to go about getting the medical card...they give you the forms, but I didn't know where to bring them, there was some place...and I went up there....And they sent me around bleedin other places to find out if I was actually me and then there was a time when I turned 18 (he found out his surname was not different from his surname on his birth cert)...you know I didn't exist on the system'* Crisis noted that the systems of health service provision were one of the main contributors to poor access for homeless people.[80] This mechanism was a major contributor to many of the external barriers and deterrents as described in Chapter 7.

#### **4. Health services designed to maximise Administrative and Cost Efficiency of Health System**

Health services need to manage the demand placed on them by patients seeking to use their services. They need to manage demand both in terms of cost efficiency and efficient time management. P-10 was put off her childhood general practitioners register *'cause I kept getting sick. He couldn't....keep up with me. I had him since I was four'*. Appointments, triage systems, detailed application forms etc. are often designed to maximise cost and time efficiency. Unfortunately, those same systems can act as deterrents and barriers for all potential patients. However, for homeless people the deterrents or barriers can be amplified by their homelessness an e.g. appointment system in hospitals where letters are sent to patient with their appointment times or appointments systems for GPs where one has to phone to make the appointment. RSTP-1H missed two appointments at a respiratory clinic due to not receiving the letter till after the appointment as he was in a different hostel. His doctor made a third appointment which he missed as he was afraid the consultant would reprimand him. CapP-W missed three appointments for her liver clinic and did not re-attend for 5 years. She died just after the research was completed from liver cirrhosis secondary to untreated hepatitis.

#### **5. Health Services designed to meet the Health Needs of Homeless People promote HSU. (42 sources/102 references)**

Some services were designed specifically to improve the HSU of homeless people. Keyworkers are workers in the homeless services who are assigned a caseload of homeless clients with whom they have to work to address a wide range of issues (e.g. housing, welfare, training, employment) including health. 'Specialised' services are primary care services that are delivered in homeless services e.g. hostels, food-halls and drop-ins. Their role is to engage homeless people who are not accessing appropriate healthcare into primary care treatment and preventative services. They also provide services that are designed to address issues that are of particular importance to homeless people e.g. methadone treatment, alcohol detox, TB and blood borne infectious screening etc. CapP-V got his psychiatric medications from specialised services and would only attend those services as he knew the doctors and nurses and felt comfortable with them. RSTP-H was most comfortable attending specialised services to the extent that when she left hospital with pneumonia, she went to the Capuchin female doctor who persuaded her to go back to



**Fig 6.14 Health Services Design not suited to Homeless Population's HSU but is suited to Domiciled Population's HSU.**

hospital. RSTP-E had not attended any health service till he met the Mobile clinic and had since attended several hospital appointments arranged from that clinic. As P-13 commented: *“The Homeless Doctors are a lot.....better to use. I wouldn’t go to the hospital now like ‘cause it’s the way I was treated.”*

## **6. Connection to Stable Emotional Support Promoted HSU.**

Having emotional connections to family, partners, children, friends or service providers generates resilience and a tendency to use health services.[99, 110, 428] P-7 referred to the fact that although his mother had a history of drug and alcohol misuse and homelessness herself, her support helped him come off drugs. P-23 described how his family would cajole and persuade him to attend the doctor. *“Do me family ever push me like, kind of? Er.....if there was something wrong with me they’d ask me to go to a doctor or “I’ll drive you up to the doctor” or whatever, you know.”*

HSU could just result from the fact of re-connecting with family. CapP-N sought methadone treatment so he could go back home for Xmas. RSTP--E went on an alcohol detox after making contact with his daughter to whom he had not spoken in 10 years.

Many participants who had children in care described accessing addiction treatment services in order to gain access to their children. CapP-C described how she was doing very well on methadone and had stopped using heroin. She also was on a benzodiazepine detox. She said she had to get clean by the end of the year or else she would lose the chance of having her child back until she was 18.

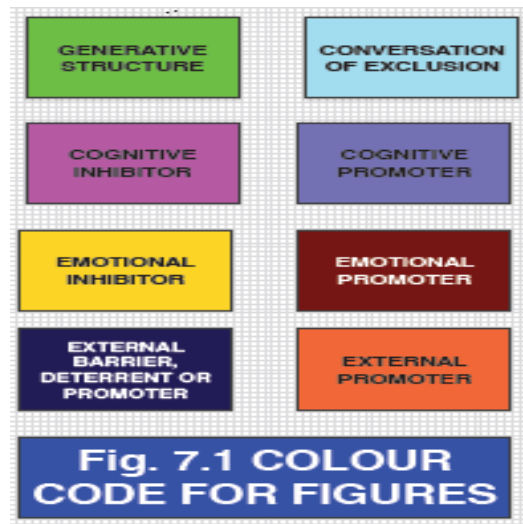
HSU also resulted from pressure brought to bear by friends on the homeless person to take care of their health. P-32: *“He was going to stop the treatment and he.....I said to him you’re mad, you’ve only four weeks left, you’re after doing five months, don’t bleedin’ stop you know. He always does say to me... fair play...only for you I’d have stopped that treatment.”*

In summary, a number of generative mechanisms for homeless people’s tendency to have differing HSU patterns from the domiciled population were identified. Some of these mechanisms took effect prior to participants becoming homeless and others were generated due to the nature of homelessness. The next chapter outlines how these mechanisms

affected HSU through the creation of external barriers, deterrents and promoters and internalised inhibitors and promoters.

## CHAPTER 7: BARRIERS, DETERRENTS INHIBITORS AND PROMOTERS OF HEALTH SERVICE UTILIZATION IN DUBLIN.

In this chapter I will describe a number of external barriers, deterrents and promoters; and internalised inhibitors and promoters to HSU for homeless people. These factors are the immediate factors influencing participants HSU. When describing these I have outlined their generative mechanisms. Finally, I will compile the generative mechanisms, barriers, deterrents, inhibitors and promoters into a critical realist model that seeks to explain why homeless people use health services differently to the domiciled population. Fig 7.1 outlines the colour code for figures in this chapter.



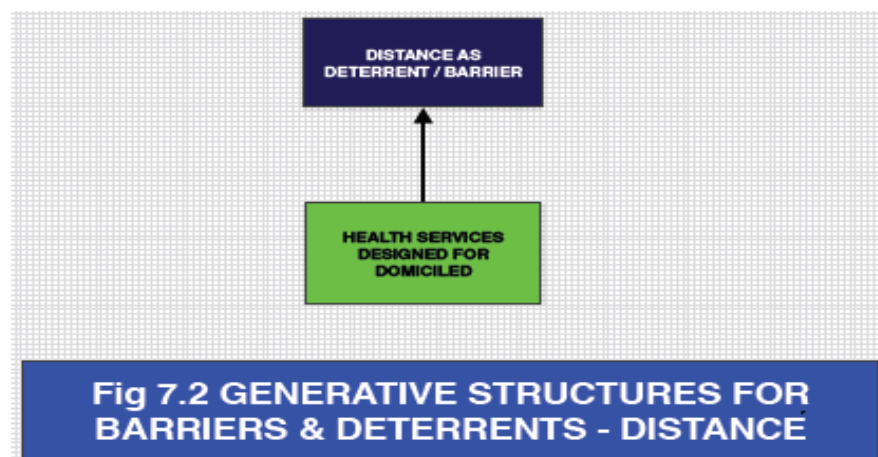
### External Barriers, Deterrents and Promoters

#### External Barriers and Deterrents.

I have divided external barriers and deterrents into four categories i.e. physical, administrative, informational or attitudinal.

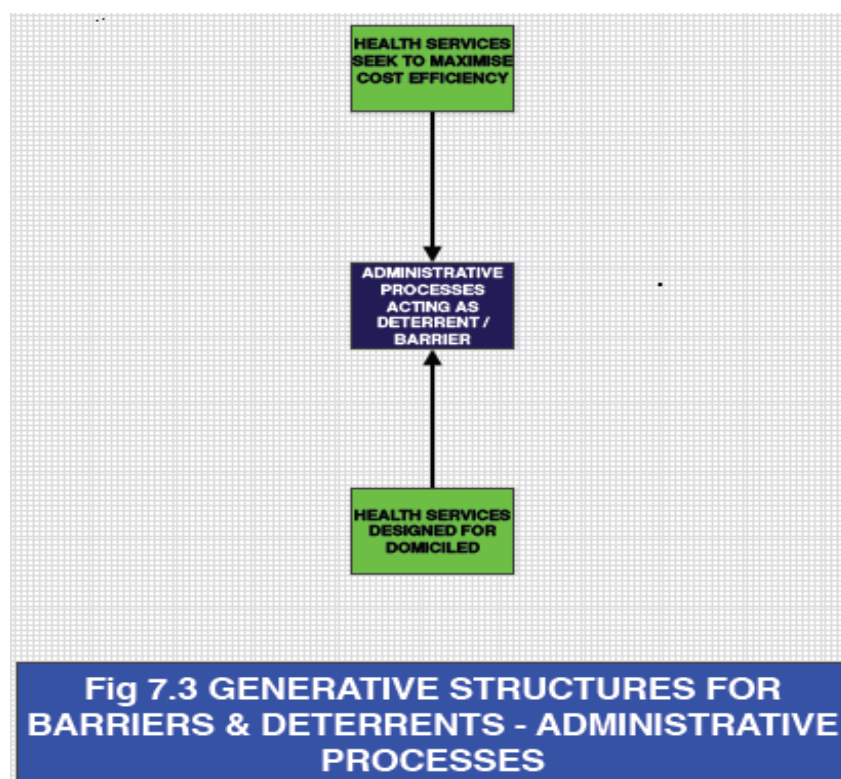
#### 1. Physical (6 sources/6 references):

##### a. Distance as deterrent. (6 sources/6 references)



Distance and lack of transport are well recognised barriers to accessing services.[164, 170, 246, 447-448] P-28 reported: *“I’d have to mainly go out to him and (it) is very far away?”*

## 2. Administrative Barriers and Deterrents (58 sources/275 references)



Homeless people are deterred by complex administrative processes and, as a result, often avoid applying for their entitlements or engaging with health services.[164, 425] It could be argued that all administrative processes are potential barriers and that creators of such procedures should be obliged to ensure they create minimum barriers for potential service users.

### a. Application Process for Medical Card as administrative deterrent/barrier (12 sources/15 references)

The obtaining of free primary care (including medication), dentistry, physiotherapy and other such services requires the granting of a medical card which is means tested. The lack of a medical card left participants exposed to significant risk of delay in receiving treatment. P-6 recounted: *“I had blood poisoning...and blood clots in my leg and I actually walked around for...a week and a half... Because I had no medical card or anything like and I was actually afraid to go up to hospital”*



The application process for a medical card has been found to be very confusing and complex for homeless people.[66] In order to obtain such a card, the applicant must first fill in a detailed form outlining their earnings (both private and welfare). This must be sent to the Health Authority who often request further information. After a lapse of time ranging from weeks to months the card is sent out by post. Many participants reported that they did not fill in the forms as they found them confusing. Some participants did not receive correspondence nor their medical cards due to changing addresses. As well as filling in the form applicants must also get a GP to sign the form accepting them as a patient. If the GP refuses to sign, the person must go to two other practices. If refused at all three practices he/she must then send in a letter to the HSE giving details of the GP's who refused and then the HSE will assign the patient to one of those GP's. The process is complex and, at the end, the person is assigned to a GP who had already refused to attend them. Several participants said they could not get GP's to sign the form and never bothered asking for a GP to be assigned to them.

The lack of a medical card also acted as a barrier to accessing hospital services. Participants reported being charged €100 to attend ED or OPD. CapP-D was reluctant to attend ED after being charged and P-4 avoided going altogether when he heard of the charge. Non-Irish participants also spoke about being issued bills for hospital stays. RSTP-1D (an Eastern European man) had been in a road traffic accident (RTA), fractured two legs and was reliant on crutches. He was awaiting surgery, but when told he would have to pay, he left.

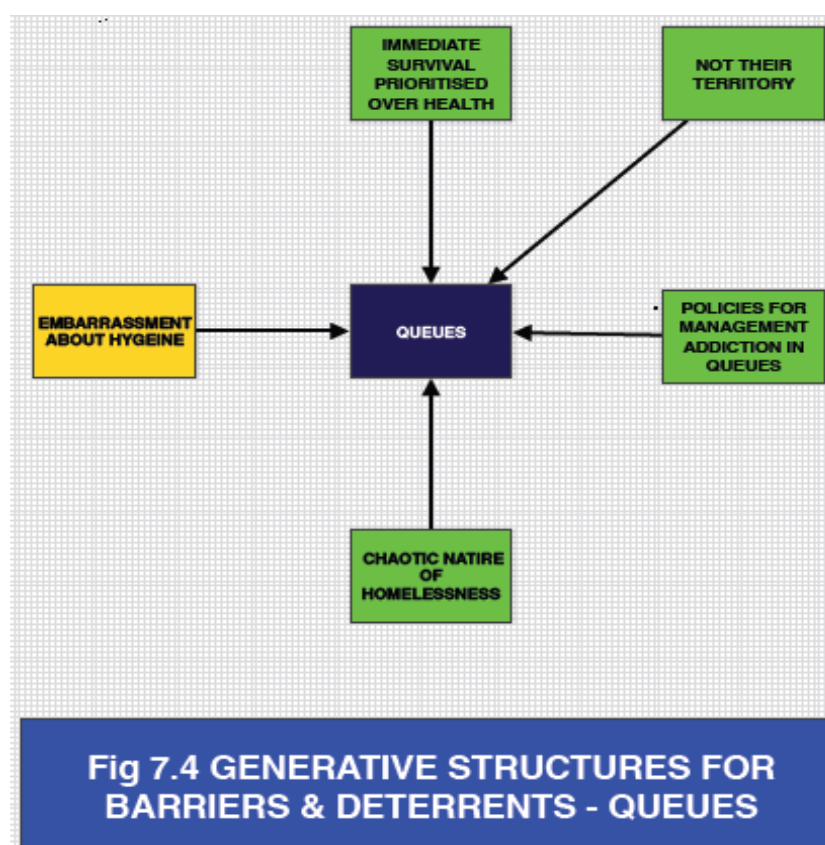
#### **b. Appointments as administrative deterrent (16 sources/26 references)**

Appointments are a well recognised deterrent for homeless people.[169, 246, 449] They are designed to allow health professionals and housed patients (with their telephones and non-chaotic schedules) to regulate their time. They are not suited to the chaotic nature of homeless persons' lives. The appointment process can break down at several junctures including when making the initial appointment, receiving the appointment by post and remembering the appointment (which, for a hospital, may be over a year away). FG1P-F: *'you wouldn't have much organisational skills or time keeping or any of them things that a normal person would just take for granted..All those appointments about your health, you really don't prioritise that.'* Many participants missed both hospital and GP appointments.

P-43: *'I have a GP...It does be difficult at times as well, you know...and then to get an appointment to see her can be difficult.'*

Some participants also described significant delays in accessing methadone treatment. P-25: *"Basically you ring and you're left waiting say.....I was waiting say nearly 6 months ago...I put in an Application Form four months ago...and I haven't heard back from them since."*

### c. Waiting Times / Queues as deterrents (18 sources/37 references)

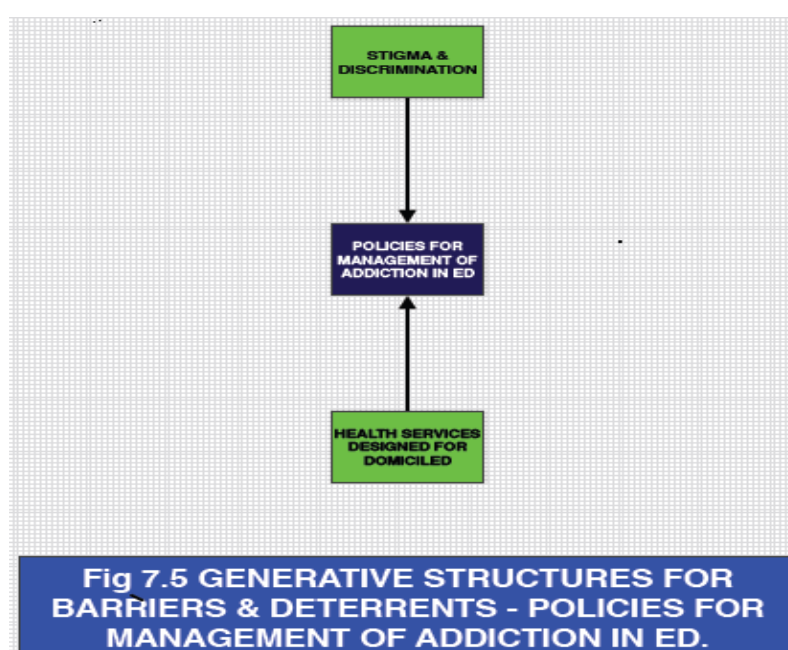


Queues are known to deter homeless people.[164] Many participants did not go to ED with serious conditions because they wanted to avoid the queues. P-7: *"Oh it was horrible like ....obviously it's a serious thing when you self harm...but if there's people coming in an ambulance being stabbed... or had cancer or someone really sick...they obviously had to be seen first.... I used to be sitting in the waiting room thinking like...what's the point of this...Like you're in like a catch 22...you know you want the help but... every minute you're there, you're down because it's getting longer and longer and then when eventually you do see a doctor or a psychologist they say you have to see a social worker, but they're not in till 12 o'clock in the morning so you're left sitting in a room...thinking man I should have*

*just done what I was thinking of doing...Because I know loads of people that have had big abscesses or looks like their foot is about to fall off and they won't go and get it seen (because of the waiting times)".*

It was interesting to note that being left in the queue was interpreted by a number of participants as discriminatory. P-25: *"There was a young girl in that was from school, that was been treated as well for breathing difficulties, and they were treating her like different, you know what I mean... and they left me sitting on a chair in the outside like."* Whether this was a perceived or real act of discrimination, the effect was the same in that it discouraged P-25 from attending.

#### **d. Policies for Management of Addiction in Emergency Department as deterrents(20 sources/48 references)**



A large number of participants pointed to the lack of medical interventions to prevent them going into withdrawal from heroin or alcohol addiction while waiting in the ED. P-23: *"The emergency.....you'd leave that to the last minute... because you're left sitting there. It could be a day before they see you even, and most drug users have to get out...get money and ...drugs. I often had to (leave the queue), I'd say most drug addicts do. When you come back you're put at the end of the queue again. You'd have to start it all again."*

Many participants did not bother to go to the ED even with serious illness. This was based on the presumption that they would not get methadone. CapP-O had being very frightened

as she had been told she possibly had TB due to changes on an x-ray done in the community. She was asked to come to hospital for a bronchoscope, but refused. The hospital would only give a detox after 24 hours and she was afraid of being in the queue for that long with withdrawals. Her friend, P-13, said he had been in similar situations and had not waited as he had to go out and score.

CapP-P was actually on prescribed methadone. However, when he had his cheek slashed in an altercation, he was left in the ED for 24 hours without methadone.

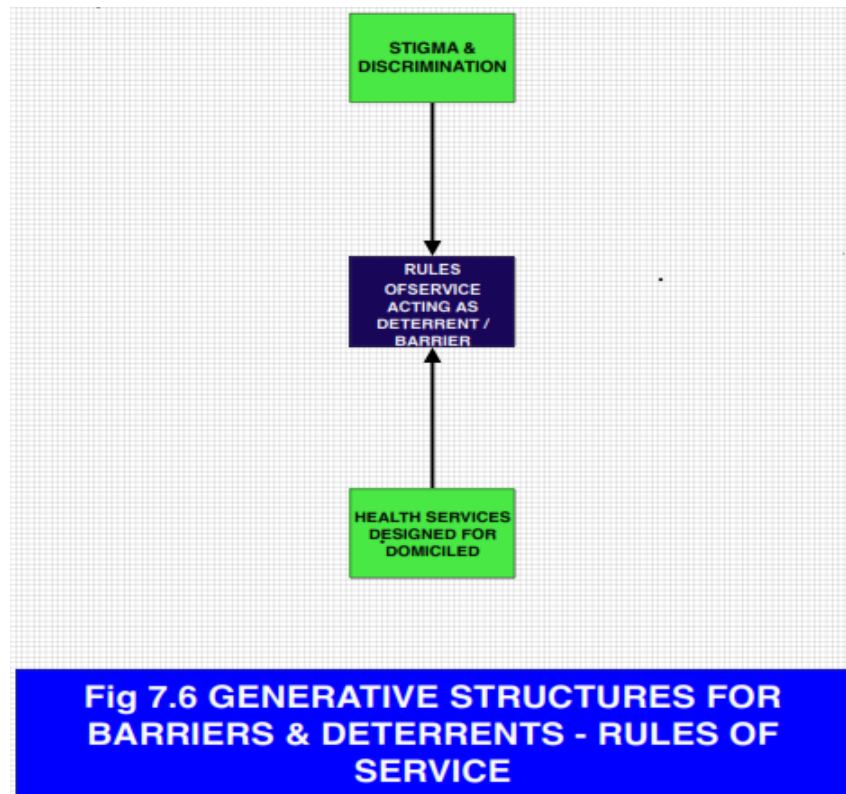
People with alcohol addiction reported the same difficulties accessing treatment to prevent withdrawal. P-20: *“I went to hospital like. Three times in four or five weeks because I was sleeping in doors and it was very cold like and I had chest pains...I left the hospital...cause you know you’d be waiting.....sitting there all night and then by the morning I suppose...it’s more important like to get some drink into you than the pains that you had the night before... so... (he left).”*

As P-6 summarised: *“It’s a catch 22 multiplied by 40.”*

#### **e. Rules of Service as deterrents. (16 sources/39 references)**

Restrictive rules act as barriers by causing negative interactions with service providing staff.[450] Challenging behaviours can be exacerbated by poorly drawn up and/or over restrictive rules.[451]

The breaking of rules or even the perception that rules were being broken often resulted creating further barriers to accessing health services. RSTP1-E attended an addiction treatment centre for methadone. He said he told his doctor he was depressed and felt suicidal and needed help. The doctor thought he was seeking drugs. He said next day he was put on a low dose methadone in the *“punishment”* room for four weeks. He felt the reason for punishing him was because he said he was depressed. He said he had not bought drugs and even if he had why punish him: *“I’m a drug addict for f..k sake* Drug users have described the manner in which drug services operate their rules as being ‘sadistic’.[452]



CapP-R (a non Irish homeless man) arrived late for his methadone and when he came back in the afternoon he was asked to come back the next day. He had an argument with the security guard and the police were called. Next day he was told he was to be barred for 3 months without any methadone. He had attended for two years without any trouble prior to this so he felt this put his life and health at risk. He started injecting into the groin. Of note he had had a clot in his leg two years previously and was on an anti-coagulant and even though he knew the risks of injecting into the groin he said he was too angry and did not care.

McVP-L (a homeless man with a diagnosis of schizophrenia) had been barred from several services (including hostels and food halls) due to talking to himself loudly (a symptom of his mental illness). He had been living in a skip. In one hostel, staff said they knew he was mentally unwell, but for the sake of the other clients they felt they had no choice but to bar him.

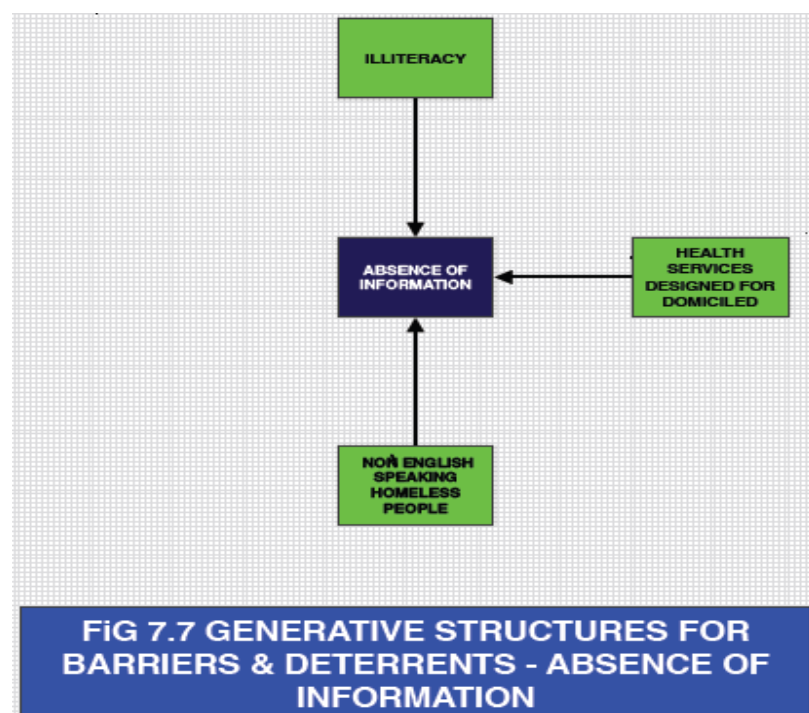
A number of respondents reported being barred by their GP's. P-18 *"No, I had a GP. He knocked me off...He just told me he didn't want to be my GP anymore... 'Cause I kept getting sick...I had him since I was four."*

P-48 had been homeless for ten years. We persuaded him to go into a hostel which had a specialised primary care service when he had pneumonia. He lost his place 3 weeks later. He had stayed most nights in the hostel, but liked to sleep out 2-3 nights a week. He was evicted from the hostel for not turning up every night. The system was too rigid to allow him sleep three nights a week.

Other administrative barriers that arose due to services not being designed for homeless people included:

- Not receiving test results due to moving address. (2 sources/ 3 references)
- Breakdown in medical care during transition from prison to community. (3 sources/4 references)
- Lack of accommodation options for couples (1 source/1reference).
- Not seeing the same doctor: (1 source/1 reference).
- Lack of official complaint procedures. (1 source/1 reference).

**f. The Presence or Absence of Information as promoter or barrier (12 sources/24 references)**



Lack of information about how to access services is a well recognised barrier.[447] A number of participants identified this as a significant administrative barrier or deterrent.

RSTP-J had an old hospital prescription for his anti-coagulant medication (for deep venous thrombosis) which he said he had not been able to get for 6 weeks as he had no doctor or medical card. He did not know where to access a GP. Another woman, CapP-G, had failed to get treatment for her pneumonia for 5 days due to not knowing how to get a doctor.

Participants also referred to not knowing the procedures for getting a medical card. P-6 felt it was his fault: *“And as well, I should have had it...a medical card, which is my responsibility to have, but.... it was just...how to go about getting the medical card and I didn’t know what to do because...I didn’t know where to bring them.”*

A significant number of people (including rough sleepers and groin injectors) referred to not having information on how to access methadone treatment.

In contrast, the presence of information promoted HSU. P-42: *“Cause we didn’t know about the HIV ...But that’s why I started going to the Doctor. I was thinking “look we need to find out about this” ...they can alleviate an awful lot of the stress by explaining things to you, you know what I mean? Like why this is happening. Because an awful lot of it is fear of the unknown.”*

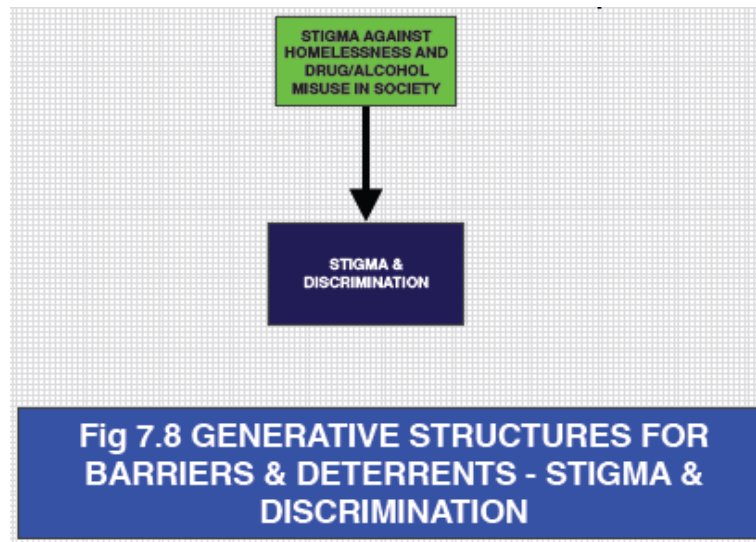
Leaflets and posters helped some clients obtain the necessary information. P-13: *“They’d give you a kind of a leaflet with doctors on it and that...Ah it’s very useful yes.”*

### **3. Attitudinal Deterrents and Barriers.**

Two attitudinal deterrents were identified during the course of the study. They were stigma/discrimination and differing attitudes as to appropriate health service usage.

#### **a. Stigma and Discrimination. (35 sources/222 references)**

It is recognised in the literature that health providers have stigmatizing attitudes towards homeless people. This stigma results firstly, as a result of active discrimination where service providers refuse to provide health services or secondly, where homeless people are deterred from using health services due to perceived discrimination.[122, 164, 169, 246, 427, 449, 453] Service providers often presume homeless people are difficult and dangerous patients who have an ‘avalanche of need’ and are unworthy of receiving services.[267, 454-455]



A number of participants (9 sources) referred to the ‘disdain’ they experienced from health professionals. P-16: *“He just looked at me as if I was bleedin dirt like.”* CapP-D was always buying new clothes to avoid looking homeless as she felt people discriminated against her when she ‘looked homeless’.

Healthcare professionals are known to stigmatise and discriminate against drug-users.[456-457] The drug-user stereotype (9 sources/25 references) seemed to be particularly pernicious. FG2P-C: *“As soon as you give them your name, you know what way you’re going to be treated...they just don’t want to know once you’re a drug addict or an ex-drug addict.”*

FG2P-C eloquently outlined doctors’ lack of understanding of the environment and social conditions that generate addiction: *“Of course, yeh, we’re ultimately responsible for what we do but if you’re living in an environment where 90% of the people are...are addicts of some sort whether its alcohol or drugs. More than likely you’re going to slip back up. But the doctors don’t see that. They don’t see...the two weeks where you’ve stayed off and the two days you’ve messed up...They just see you arriving back in hospital and no change.”*

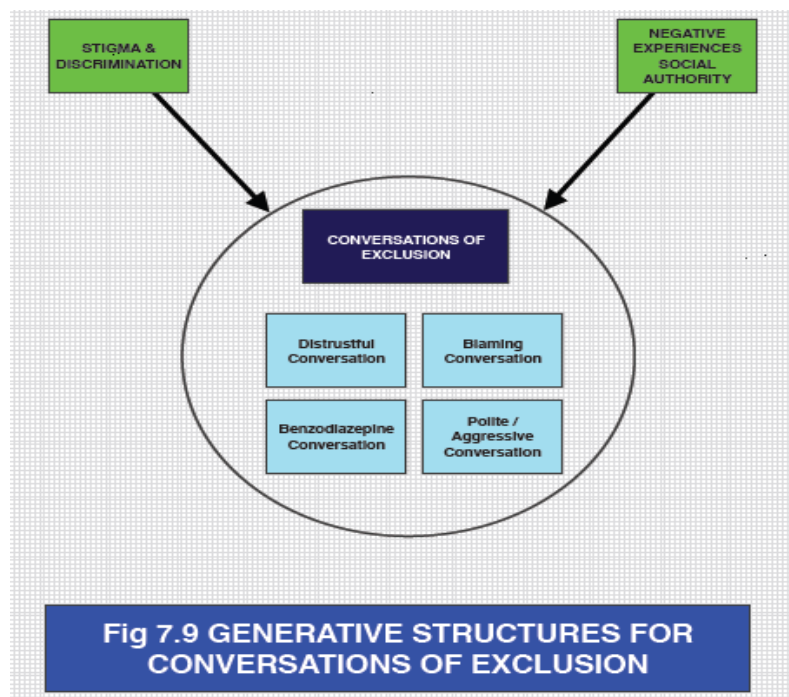
Non-nationals outlined how they had experienced racist attitudes and behaviours from other homeless people, although not from health professionals. This racism deterred them from attending many hostels or drop-in services. They used particular services that they perceived as being friendly to migrants e.g. the Capuchin food-hall.



### **b. Differing Attitudes as to Appropriate Health Service Usage.**

Service providers and homeless users have differing ideas as to how health services should be utilised and service providers display negative attitudes to those who are perceived to use those services ‘inappropriately’.[148] Service providers and participants had differing attitudes as to what was appropriate usage of services.

I describe four interactions between service providers and users which resulted in the user either being excluded or excluding themselves from that service. I describe these as ‘conversations of exclusion.’ These interactions often deteriorated due to both participants have differing understandings as to the nature and purpose of the interaction.



#### **(i). The Benzo conversation (22 sources/79 references).**

In this conversation the homeless benzodiazepine-taking person assumes (not unreasonably) that doctors should give them benzodiazepines to improve their health by preventing them going into withdrawals or by helping them to sleep. In fact a number of participants reported that homelessness was a factor in their insomnia. (5 sources/10 references) P25: *“that is a lot of a strain...I needed them cos...it was the only thing that would get me to sleep, ?”* Doctors, on the other hand, feel ambivalent about prescribing benzodiazepine as they assume they will impact negatively on health due to their addictive potential. Furthermore, they do not wish to be seen as an over-prescriber amongst their

peers.[458-460] This ambivalence combined with the negative stereotypes held by GPs of drug mis-users creates the potential for a clash between doctor and patient prior to them even meeting. This potential can be further exacerbated as drug-users feel that they are the ‘experts’ on the effect of addiction on their personal lives.[461-462]

The benzodiazepine conversation was described by McVP-M, a young woman addicted to heroin and benzodiazepines who had contracted both HIV and Hepatitis C. She described how the doctor would respond angrily, once she asked for benzodiazepines This would get her back up, she would ask the doctor “*why not*” and then the interaction would degenerate into an argument which would end with her leaving. McVP-K said she had gone to doctors and: “*once they hear you asking for benzos they get very angry.*” P-23 described how once the doctor realizes you have a drug habit they presume you will be seeking drugs, the doctor will then become frightened and this inhibits the conducting of a proper consultation.

The conversation can also be initiated by the doctor who predicts the patient will ask for benzodiazepines. P-12: “*Ah he’d say “whatever you do don’t start asking me for Benzo’s”. It’s just the first thing he’d say and I wouldn’t be asking him for nothing...Like a check up or I can’t breathe...You know from sleeping out in the cold and me hips pained me a lot... I slept rough for four years solid.*” (The doctor would say) “*No, I don’t give Benzo’s*”. *I say “I didn’t ask you”. And then you’d get into an argument with him and I’d walk out.*”

McVP-B described how the discrimination would spread due to doctors sharing stories. Her own doctor suddenly stopped her benzodiazepines and told her to go get another GP. So she went to another GP, the next time she was ill. The new GP made a phone call at the start of her consultation and she heard him talking to her first GP and at the end of the conversation he turned to her and said he wasn’t going to give her anything and not to come back. Exclusion from a medical service is the ultimate sanction and has been shown to be deleterious to health.[463-466]

The Benzo conversation also took place in hospital settings. FG2P-C: “*I went in completely clean and they found I had a drug history. There was a guy that broke his finger and he had a morphine line, they wouldn’t give me so much as a panadol. Then they hit a nerve; they thought I was lying when I said you’ve hit a nerve. They thought...he*

*wants his opiates...I shattered my heel, my ankle and split the base of my shin with a bit of my ankle bone”*

Eventually, the patient internalises this deterrent and develops the belief that there is no point going to the health professional as they will simply presume they are looking for benzos and not treat him/her. So the homeless benzodiazepine-taking person avoids going to the health service. P-15: *“I have problems in me family, and I’m anxious about that...I feel if I went in and told the doctor that, that he’d just turn around and say “Ah, he’s just looking for fuckin tablets...So I don’t bother ...He sees me as a junkie.”*

## **(ii). The Distrustful Conversation (19 sources/66 references)**

Homeless people have to resort to deception or ‘trickery’ in order to survive. Scamming, ruses, criminal activity are all part of the survival strategy for homeless people. Kim Lee (1993) suggests that these behaviours are often effected in zones of oppression in ways where its subtlety cannot be detected. The tragedy of trickery is that is that homeless people are forced through necessity to become mendacious and ‘untrustworthy’.[467] This distrust often leads to exclusion for homeless people from services.[463]

Doctors have been warned to be wary of drug users’ manipulative behaviour and to adopt a distrusting stance in such relationships.[468-469] FG2D-X: *“So I felt very annoyed that someone that I had treated with respect was lying to get the prescription...that really kind of pissed me off...You know you do your best, you treat someone with respect and then they turn around and they treat you like that. It will probably make me more suspicious, less trusting.”*

However, for homeless people telling a lie was essential to get their needs met because the health system would not offer them what they felt they needed if they told the truth, FG2P-C: *“The thing about the drug addiction is...you do manipulate, you lie and you do coerce when you want that drug. You’ll say mass and you’ll promise the moon.”*

Other drug-using patients lied to avoid facing negative consequences. P-43: *“Well I don’t want to say it to me Methadone doctor.....about drink...Because he’d take me off me takeaways.”* CapP-T said she told the doctor she was not drinking as she was afraid of losing access to her children if the doctor realised she was developing a drink habit.

Several patients avoided telling their doctors about drug-related infections (e.g. abscesses) or depressive symptoms in case their methadone takeaways were withdrawn or dosage reduced (which is contra-intuitive as increased usage would usually warrant increased dosage). Other patients told lies to obtain the help they needed but would not have been offered if they had been truthful. Three people told me how they told lies to be kept in hospital so they could have shelter. EDP-A: *“I went in and I told them I’d chest pain, I just wanted to stay the night ...They ended up keeping me in for the week.”*

P 26 described whimsically how he would have been better off telling a lie when he had taken an overdose as he felt the doctors could not just understand the truth: *“It probably would have made more sense to say I’d try to kill meself instead of “I just wanted to get high”, you know, It wasn’t a very good answer.”*

This presumption that trust is essential for a good relationship was not universal. In the research I noted that many outreach and key-workers made no presumption that participants would tell the truth. They did not take offence if they were told a lie perceiving it as a normal survival behaviour for homeless people.

Interestingly, homeless persons’ accounts of the severity of illness and their need for medical care can be trusted.[470] Homeless patients found themselves being distrusted by doctors even when telling the truth. McVP-D said he was asked to leave a doctor when he went for a chest infection because the doctor thought he was looking for benzos: *“and I wasn’t even looking for them.”*

The development of trust has been identified as a prerequisite to engagement and homeless people often mistrust health services.[169, 448, 451, 453, 471] CapP-S had dabbled in ecstasy as a teenager. He went to the psychiatric clinic for help when his mother found out and they said that since he had been using ecstasy he had no psychiatric illness and discharged him. His mother put him out of the house. He blames all doctors for his becoming homeless and for his drug use and so finds it very hard to develop a relationship with any doctor. A number of participants (mainly female), who had children, referred to their distrust of health professionals as they feared that they would be involved in either taking their children from them or preventing access.

**(iii). The Blaming Conversation.** (4 sources/17 references)

The blaming interaction is where the health professional blames the patient for causing his/her own health problems. FG2D-Y: *“They told me in the A&E that they couldn’t take me in because I was a drug addict and I made my own choices.”*

Even when the patient’s behaviour was not contributing to their medical problem they were being blamed. P-9: *“Because I was going in to the hospital and I was following up my treatment for me leg. It felt like “what are you still coming in for, you’re a heroin addict. You’re still injecting and all that”. I wasn’t injecting into me leg after that. I was still injecting into my arms.”*

FG1D-F inadvertently owned up to blaming homeless drug users for not following up on their medical advice or appointments: *“I don’t get angry with people but I do get frustrated with them. From their point of view, they’re doing themselves a disservice...they come back again with the same problem...I’m just like “Oh why didn’t you get it done? Something terrible could have happened to you.” I suppose it’s that they’re doing themselves a disservice. So you are getting angry.”*

The blaming conversation serves to alienate homeless people and interferes with out ability to provide appropriate services.[472]

**(iv). The Assertiveness Conversation.**

This conversation related to the fact that people from the mainstream housed population are likely to assert themselves in a polite manner, whereas homeless people have an ‘*expectation of rejection, and anger can be quite near the surface...(that)...can spark off aggressive behaviour.*’[473-474] They tend to have differing assumptions as to what is an acceptable way to assert oneself. I persuaded RSTP-1G to go to ED for assessment of a head injury and accompanied him. He walked up to the receptionist in an aggressive manner and immediately got into an argument where the receptionist looked frightened. He got frustrated and started to walk out. If I had not acted as an intermediary he would have not received treatment. It demonstrated to me how aggressiveness is but an ineffective assertiveness approach. P-7 described to me once how he could get what he needed from the relevant services as he had been taught how to be polite by his foster home. He learnt the discourse for traversing professional health facilities.

FG2P-C described this difference in conversation as being related to class. FG2P-C: *“It is a class thing and a lack of education...He made me feel tiny. He spoke down to me, he belittled me and when I tried to let him know that I was taking them to get a high and I didn’t realise they were anti-depressants. Then he started to speak, he used a bit of Latin...he tried to let me know that ‘I’m going to spout a load of Latin at you and let you know you know absolutely jack.’*

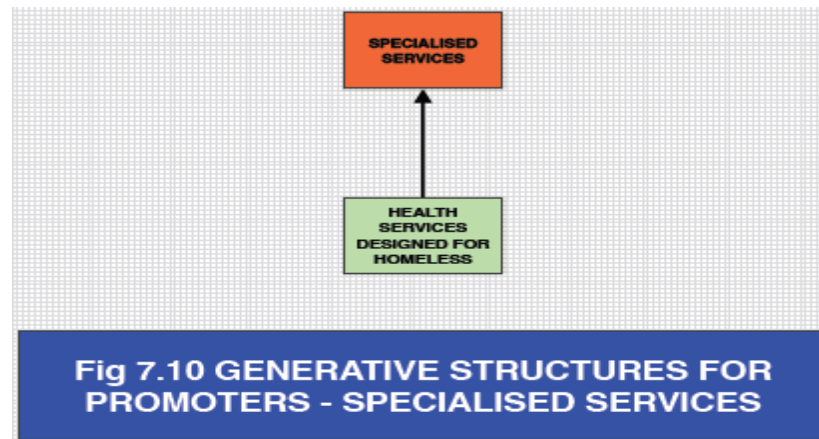
He further noted how class difference meant doctors had no understanding of the experiences of those who were homeless and drug-using. FG2P-C: *“I think that we generalise too much towards each other as addicts and as doctors. There’s too much - you’ve done this to yourself. If you break it down, every medical issue is self inflicted. And as regards the drug thing, a lot of addicts get into it ridiculously young, there’s a lack of education and sometimes just plain ignorance because there’s usually an underlying reason for them taking that drug. Usually to avoid or hide bad memories from their lives or childhood or whatnot because usually there are broken homes or socio-economic things involved.”*

## **External Promoters**

### **a. Specialised Services (32 sources/76 references)**

Specialised services improved access. Forty-five of the participants had attended specialised services for issues as disparate as methadone treatment, dressings for ulcers, skin infections, groin abscesses, deep venous thromboses, orbital cellulitis, pneumonia, asthma, mental health problems, headaches, chest or ear injections, injuries, and filling out hospital prescriptions. As P-19 said: *“A lot of people use the service that are homeless.”* Some participants said they would have used the ED if they had not had the option of using specialised services.

P6 described how he would have been unable to afford his medicines post discharge from hospital if it had not been for specialised services.



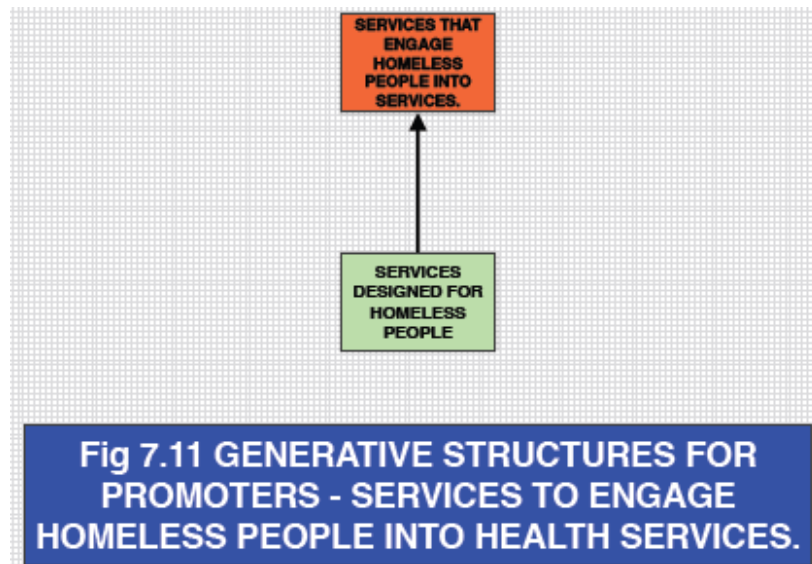
Several respondents referred to how easy it was to access specialised services. CapP-V had no medical card. He had both mental and physical health problems. He got all his medications from a specialised service in the hostel. P-25: *"I found it a lot easier to access the likes of them...you can't like just go and make an appointment with your doctor if you need to see your doctor."*

Services that are flexible, empathic, non-stigmatizing, supportive and demonstrate respect for their clients were more likely to engage the homeless person.[91, 108, 169, 242-243, 319, 473, 475] P-9: *"The Homeless Doctors are a lot more.....better to use. I wouldn't go to the hospital now like 'cause it's the way I was treated."* P-12: *"cause their getting down to my level...these are guys I can more or less trust."*

RSTP-E had not been able to access health care except for the accident and emergency until he started using the mobile health clinic as he had no medical card and did not know how to get one.

As with previous research, providing specialised services where homeless people could obtain food, such as the Capuchin centre, promoted or encouraged HSU.[450]

**b. Services that engaged homeless people into health services. (16 sources/26 references)**



I experienced many occasions where keyworkers played a critical role in getting homeless people to attend health services. One example from many was how OW1, worked with her clients. OW1 is extremely popular among the homeless population. She really cares for her clients. I witnessed many occasions where, in private, when she would become visibly upset at the situation many of her clients found themselves in. Her clients knew she cared. They witnessed the lengths she would go to help them. One night we met RSTP-Q (a young deaf homeless man) who was very upset as he had been put out of his regular accommodation. He felt he would be at risk of being attacked in the alternative accommodation offered by the freephone service. Despite telling them of his concerns, no other alternative was offered. He was communicating with OW1 who had learnt sign language specifically for him. He was becoming increasingly upset at what he felt was the unjust way he was being treated. He eventually made a sign as if he was going to go and hang himself. OW1 said she would try and get him a bed. Eventually he walked outside and went to cross the street. OW1 followed him and walked across and was knocked down by a car. Luckily, she was only bruised on her arm and shin. Meantime RSTP-Q walked off. She told me later how she was upset as she was afraid he was going to hang himself. She once had brought a homeless client to the ED who was threatening to commit suicide and pleaded to have him admitted as she had a strong feeling he was going to commit suicide. The psychiatrist discharged him and he went out and drowned himself in the canal. Later OW2 from the RST and I found RSTP-Q. OW1 organised the doctor to review him



and she rang someone she knew in a hostel to seek a bed. This was against the administrative rules. This demonstrated not only how keyworker support was crucial for many clients but also how they sometimes had to break the administrative rules to meet client needs.

P-7 described how OW1 had been there to support him including connecting him to health services: *“Yeah, she worked with me since I’m 18 I think like ... without her, I probably wouldn’t have been able to do that cos...I don’t know really how to get in touch with doctors ....she made that big stepping stone like possible for me...like she was always there...she’d advise me on things...like any time I’ve been in hospital or anything..., she’s always coming up to see me and brought up smokes and all like...I know she’s a worker but she’s been there like with my family, so she’s like....kind of like a family like member...like you know the one you can rely on...like...I’d be lost without her really yeah...definitely like...just someone to talk to ...to...that knows where you’re coming from... that we don’t really have that like what our family like so...like it means the world sometimes like you know...for me anyways like.”*

Participants also described how external pressure from health workers improved HSU. A number of participants had to take HIV medication with their methadone or they would not be given methadone. P-1 had severe leg ulcers which had improved dramatically due to his doctor not dispensing the methadone until P-1 had his ulcers dressed by a nurse.

### **Internal Inhibitors and Promoters**

In the course of both the field work and the analysis stages of the research I started to notice certain recurring cognitions and emotions that either negatively or positively impacted on the homeless persons HSU. Though these cognitions and emotions were internal, they usually derived from external factors in participants’ socio-cultural environment. As I perceive the origin of these factors to be external I refer to these processes as Internalised (as opposed to Internal) Inhibitors and promoters i.e. the person is exposed to a particular belief or experience that results in them internalising that same belief (e.g. you are to blame for your own predicament) or internalising the predictability of their experience (e.g. no point going to ask doctors to sign a medical card as they will continue to refuse me). More than one cognition or emotion can affect a certain behaviour while the interaction between emotions and cognitions often impacts on HSU e.g. fear of

disease can result in a cognitive denial of the presence of possible symptoms of that disease.

### **Internalised Cognitive Inhibitors.**

1. Fatalistic Cognitions (18 sources/47 references)
2. Denial Cognitions (18 sources/45 references)
3. Presumption of Poor Treatment due to personal past experience or due to hearing of other people's negative experiences (15 sources/33 references)
4. Self Blame Cognitions (12 sources/37 references)
5. Presumption of Discrimination Cognitions (11 sources/33 references)
6. Deferral to the Future Cognitions. (6 sources/11 references)
7. Competing Priorities Cognitions. (35 sources/99 references)

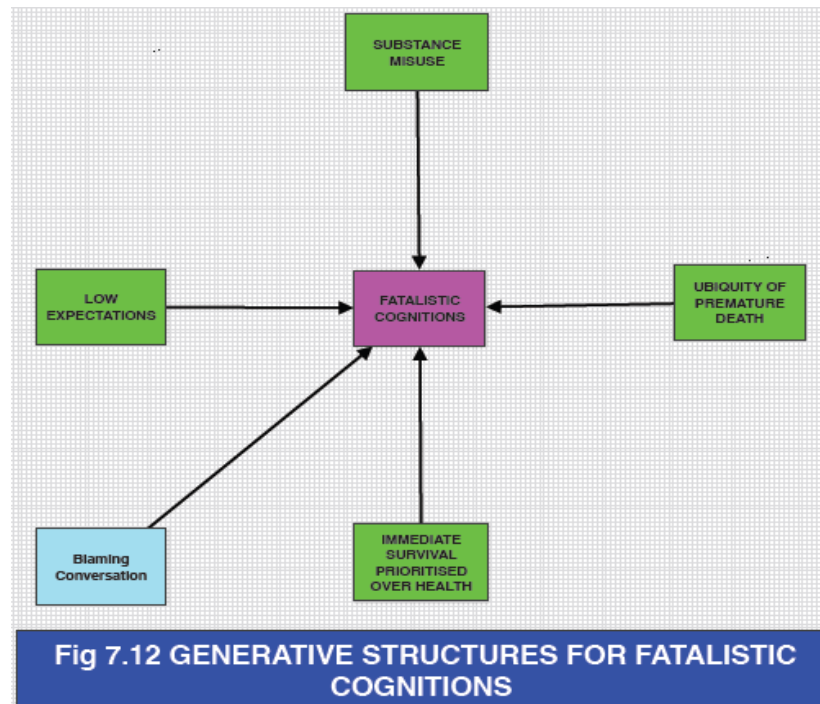
#### **1. Fatalistic Cognitions (18 sources/47 references)**

Several authors have noted homeless people displaying fatalistic attitudes.[477-478] Participants referred to fatalistic cognitions they had. P-41: *"You don't know if you're going to go or not, you know. What can you do...If I'm going to die, I'm going to die."*

This fatalism has been related to the witnessing of many young deaths in homelessness.[434] Several respondents believed they had a shortened life span. P-18: *"I don't care about me life...I can see death, in me... And it is going to happen someday. I think it's going to be very soon... I didn't expect to live very long either."*

Other people seemed not to care about their health and took risks that, in the past, had resulted in serious illness. RSTP-A had a history of a cardiac valve defect and had had sub-acute bacterial endocarditis in the past. She said she realised that this was serious and that injecting heroin was dangerous and could cause another attack of SBE but she had the fatalistic attitude: *"if it happens it happens."*

For P-20 was not fatalistic about his potentially shortened life span but was about what he could achieve with what was left of his life: *"I feel...my life's going to be shorter ... I suppose I'm 36 years of age now. I'm not going to start raising a family now like. It's a bit late for me to start now like."*



Several participants when asked why they tended not to go to health services used referred to ‘carrying on with it’. P-10: *“Just take one day at a time.”*

## 2. Denial Cognitions (18 sources/45 references)

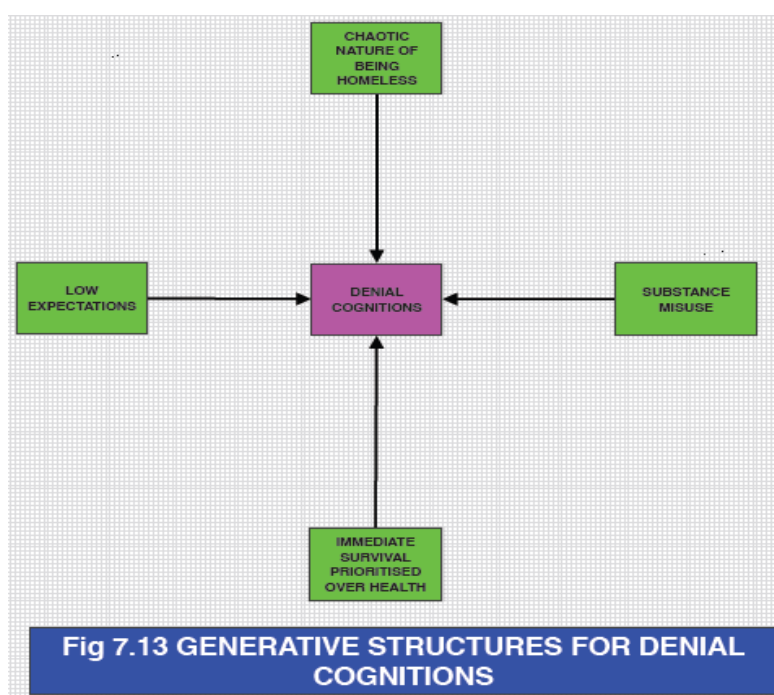
Both poverty and homelessness are associated with denial of having serious physical and mental illness.[274, 451-452, 479-480] This is known to inhibit HSU.[265] FG1P-E: *“Everybody has a choice. I just wasn’t listening and was in denial with my health.”*

RSTP-O had been coughing up blood for a few months. She had no medical card and so had not gone to see a GP. She said she was too busy during the daytime to worry about seeing a doctor.

Several participants just did not want to hear bad news. P-14 recounted how she avoided going to see the doctor as it was coming up to Xmas and it was: *“supposed to be a happy time with the kids, but it’s not happy in my place at the moment, but we just have to get through it.”*

A number of people with HIV described being in denial. P-11 missed her OPD HIV appointment: *“It’s way pushed at the back of me head. I will not let that fuckin disease beat me. I do think about it too and I do say “stop thinking about it. Don’t let this take*

over.” For her going to the HIV clinic: *“makes it so real...Seeing all sick people around you.”*



For P-5, denial was about not recognising that there was support for her to address her addiction issues: *“There was support they had given to me, but I just didn’t turn up because I didn’t want to believe that it was happening to me....so I just kept my head buried and just kept taking the drugs”*

Part of the denial cognition was that homeless participants seemed to have a different approach to analysing the risk/benefit ratio for taking health risks and attending health services (10 sources/17 references). McVP-H described a swollen leg which sounded as if there was a high probability it could have been a deep venous thrombosis (DVT). However, despite me, a doctor, pointing this out, he decided not to go to the ED as he thought it probably was not a clot and it was a fair risk to take. Neither I nor my peers would have taken that risk.

A number of participants described playing Russian roulette with the risk of contracting HIV or hepatitis either through sharing needles or not using protection. P-37 used dirty works: *“We went to a house, picked up a needle there, went to another house, picked up a*

*syringe there. There was a bit of blood on one of them, I don't know which one it was. Kept flushing it for a half hour, thinking yeah, it's grand."*

P-30 only once ever shared a needle and contracted hepatitis C: *"Shared a needle. Stupid...I was 14...I was traumatised because I was raped and then after that I did it. That's why I did it."*

P35 contracted hepatitis C on purpose: *"I gave it to myself on purpose...Because the partner that I was with at the time, had it and I had to try and convince her that I loved her...I injected her blood into me leg...And now she's dead."*

Risk taking also happened with sexual behaviours. P-42 had unprotected sex with her partner who was HIV positive. She knew the risk but was willing to take it as getting infected was only: *"a possibility"*. P-19 was HIV positive and was not using protection during sex. He was also not taking his anti-retroviral medication and so was likely to have had a high viral load which would have increased the risk of his transmitting HIV.

### **3. Presumption of Poor Treatment (15 sources/33 references)**

Homeless people have been found to be distrustful of health professionals due to poor previous experiences.[84, 264, 451, 453] P-15 had a bad experience which deterred her from attending again: *"He was roaring and shouting at you. "Why you come this late...you could have come this morning" ...Because he wanted it all done that morning."*

Sometimes a negative experience meant the user would not attend that and all similar services.

**FG2P-A:** *"Yeah I won't go near that hospital."*

**FG2P-H:** *"I don't blame you"*

**FG2P-B:** *"It deters you from going there?"*

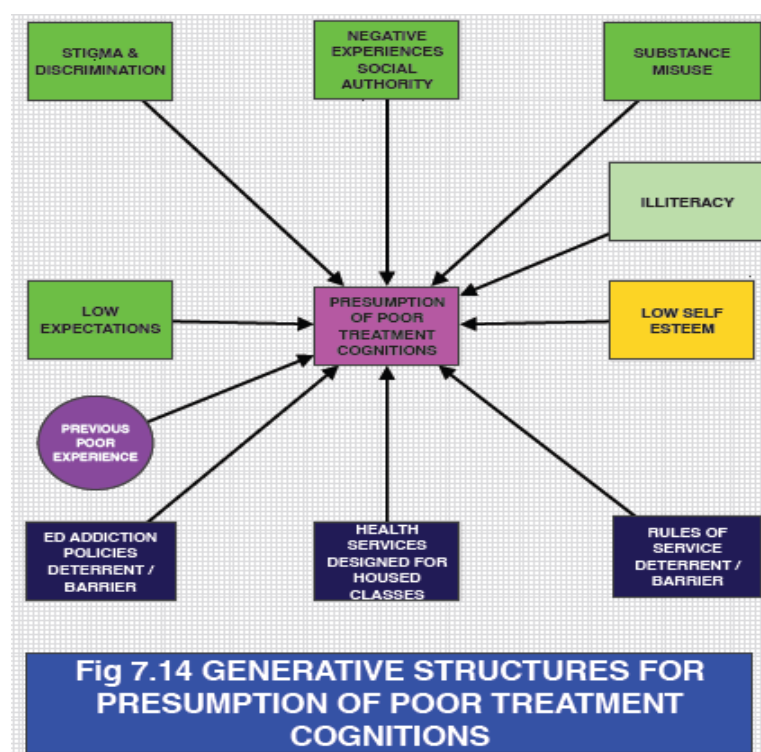
**FG2P-A:** *"Oh yeh, of course it does."*

**FG2P-B:** *"Have you ever been back since?"*

**FG2P-A:** *"No."*

**FG2P-B:** *"Did you go to another hospital. Like if you were needing to go to the hospital? Did you go elsewhere?"*

**FG2P-A:** “No, I’m not going to any hospital.”

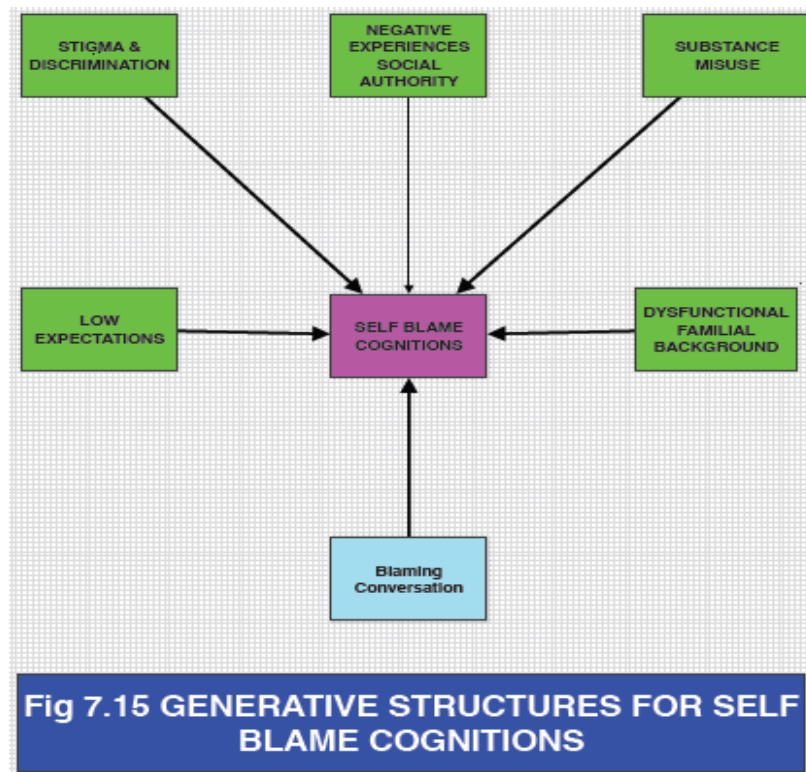


Hearing negative experiences of treatment related by family, friends or acquaintances also had a negative influence on participants HSU. P-46 decided not to go for hepatitis treatment due to such a story: *“I actually was talking to a girl there... she goes “Oh it’s just taking lumps out of me”...but that’s actually what frightened me.”*

Rumours had a strong influence on participants’ decisions as to whether to use a health service or not. P-12: *“Well, there are a lot of rumours about Triple Therapy (i.e. medication for HIV).....goes around...Like....don’t take that, it’ll make you very sick. It eats up half of your methadone. You get very sick, you’ll lose your hair.....you know.”*

#### **4. Self Blame Cognitions (12 sources/37 references)**

Homeless people have a tendency to self-blame including taking blame for being homeless.[481-482] Social stigma has been identified as a particularly powerful contributor to this self-blame.[238, 483-484] Parker & Fopp (2004) felt that self-blame reflected the dominant societal discourse being internalised by homeless people.[484]



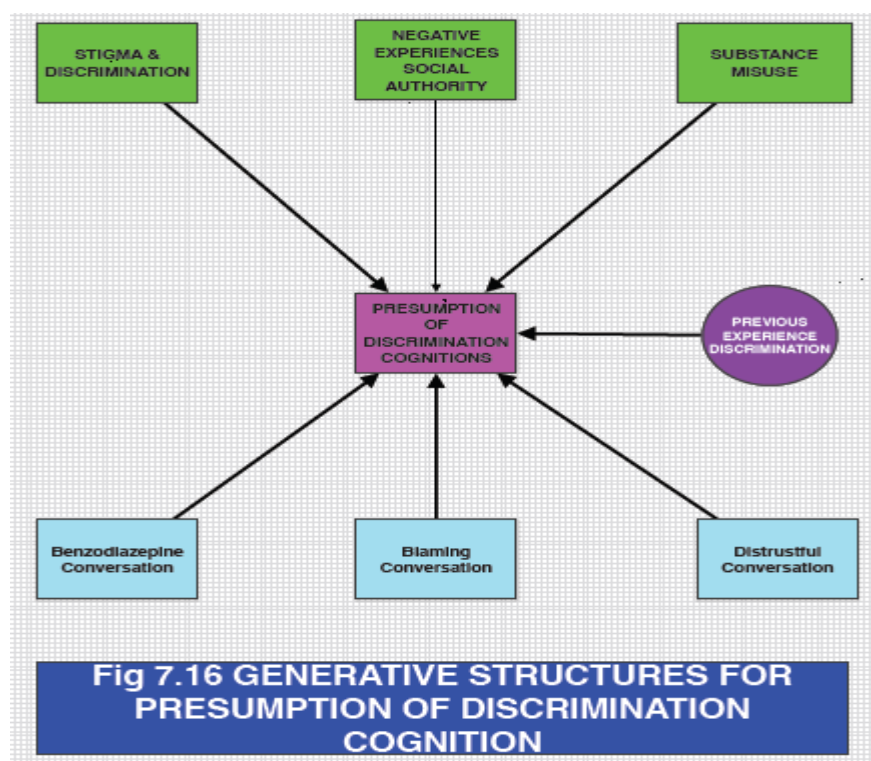
A number of participants believed that as their health conditions were related to their drug or alcohol usage that it was their own fault and they did not deserve treatment. P-13 decided not to attend the Emergency Department for shortness of breath related to a chest infection as: *“I just thought it was the drink, you know...I thought the doctor would just say “give up the drink”... Sometimes you feel like that too, only wasting their time, you know. There’s somebody out there who needs the help more than you need it...Because I’m a drinker and it’s my own fault. It’s the way people look sometimes, you know. Look on myself...It’s self inflicted”, you know.”*

For FGIP-A feeling responsible for his own addiction meant he accepted significant prejudicial and discriminatory treatment: *“They told me in the A&E that they couldn’t take me in because I was a drug addict. “*

## 5. Presumption of Discrimination Cognitions (11 sources/31 references)

Many homeless people expect to be stigmatised often due to previous discriminatory experiences and so avoid engaging with health services.[164, 246, 471. 474] P-23 said this presumption of discrimination was widespread amongst drug users: *“Most drug addicts think GPs ..... if you go in with any illness as soon as they hear you’re on drugs...they’re going to start talking down to them and treating them different...most people that’s on*

*drugs...kind of keep away from doctors...Well there is doctors out there the minute they hear you are on drugs...they kind of give you a wide berth, you know that way."*

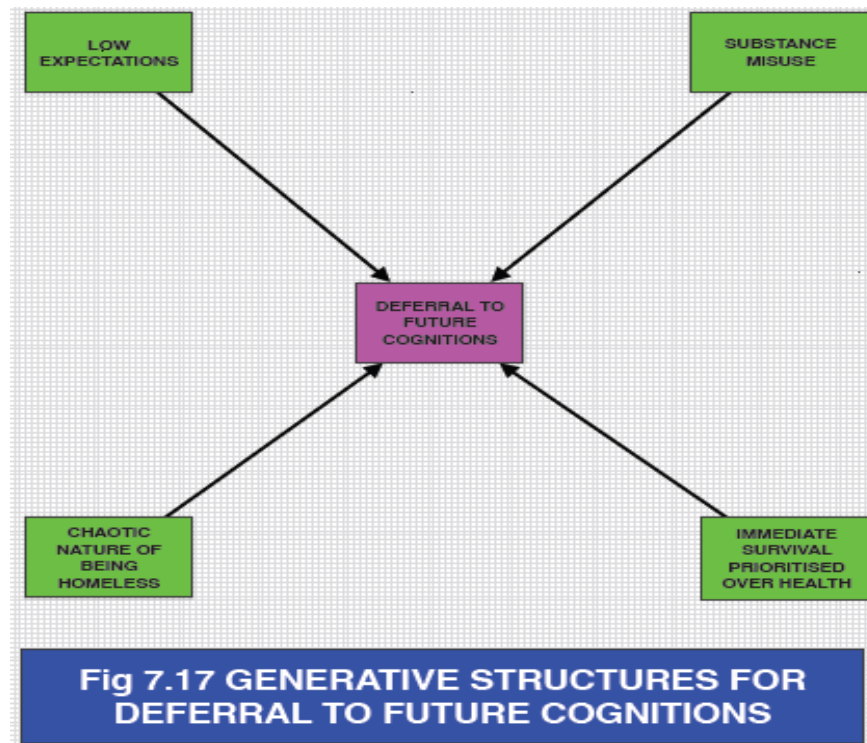


This presumption of discrimination was doubly potent due to the fact that participants presumed they were so discriminated against, they could not make a complaint about poor treatment. I asked MCVP-H why did he leave the first hospital and not go in and complain. He said they probably wouldn't have listened to me as he looked like someone who used drugs.

## 6. Deferral to the Future Cognitions. (6 sources/11 references)

Some participants kept on deferring HSU to the future. The witnessing of many young deaths can lead to the development of a sense of living in the moment, taking one day at a time, and deferring non-immediate priorities to the future.[434, 485] P-7: *"obviously if I'd have gone to the doctor like, I would have probably been able to make a plan...at the time ...thinking aw it'll be get through tonight and then I'll worry about tomorrow."*





## 7. Competing Priorities Cognitions. (35 Sources/99 references).

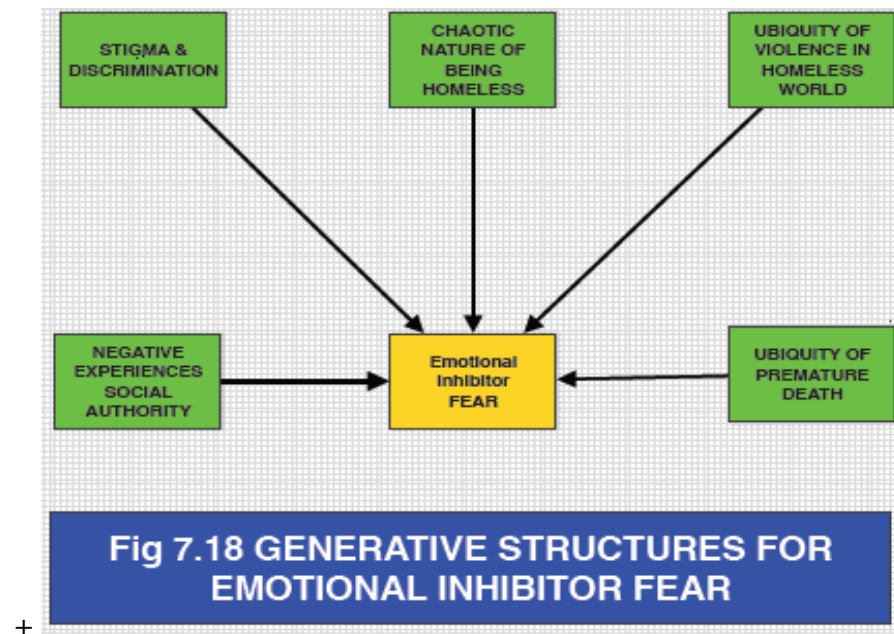
Many participants referred to them having ‘survival’ needs that they prioritised over obtaining healthcare. These competing priorities have already been referred to in the section on generative mechanisms.

As well as cognitions I identified a number of emotional states that reduced the probability of using a health service. As with the cognitions I outlined, many of these emotions were aroused by external events or interactions and so, as with cognitions, I have termed them internalised emotional inhibitors.

These emotions are as follows:

1. Fear (35 sources/96 references)
2. Hopelessness (18 sources/36 references)
3. Embarrassment (11 sources/30 references)
4. Low self-esteem (8 sources/20 references)
5. Anger (8 sources/14 references)
6. Fearlessness

## 1. Fear (35 sources/96 references)



Homeless people live their lives both on the street and in hostels in persistent fear of assault; stigmatization; having their possessions stolen and of their children being put into care or becoming involved in drugs or crime.[99, 434, 447, 486] Many participants avoided services that were essential for their health due to fear of encountering aggression or violence. Methadone treatment centres were mentioned in particular. P42: *“My partner like he wants off the Clinic...he was.....jumped on...Verbal confrontation and then bang.....youngsters for some reason, their answer to everything is violence.”*

Emergency hostels were also perceived by many participants to be dangerous. P-48 who was an elderly rough sleeping drinker was afraid of the drug users in these hostels and would not go in even when he had pneumonia. He chose to sleep rough in a Dublin suburb which, as he said, was: *“all safe they are... quiet out there it is ”* RSTP-Z would not go into hostels or food halls as he had a history of sexually assaulting a 13 year old and so felt at risk of assault if he was recognised in a hostel.

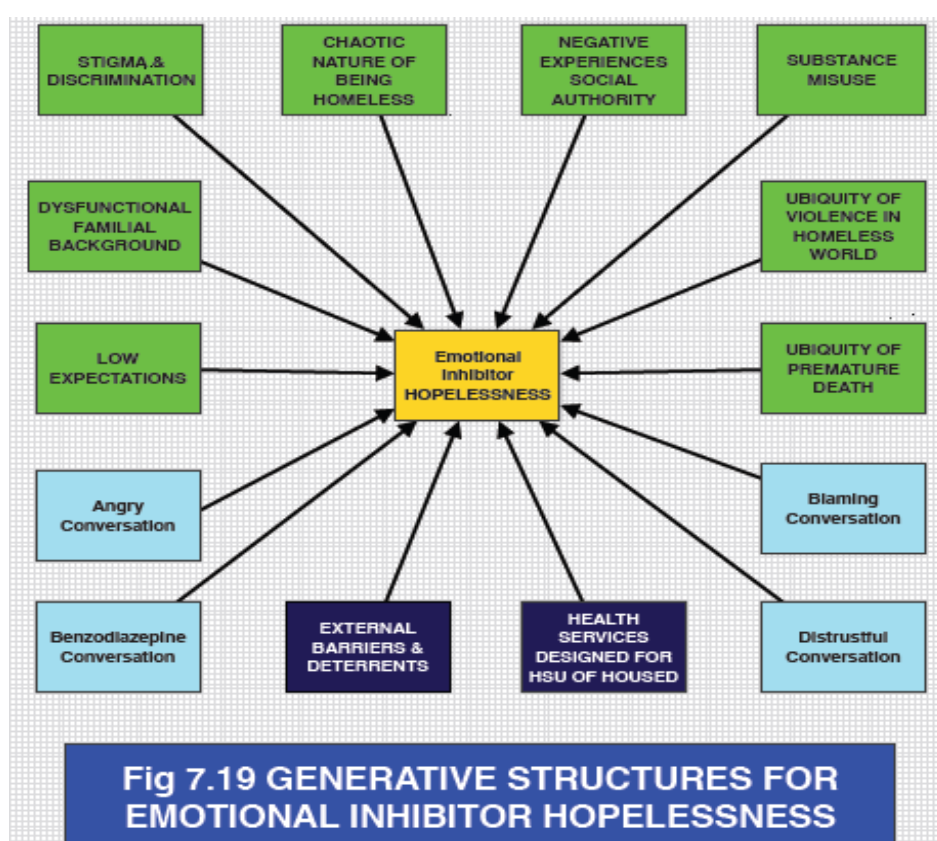
Fear of authority figures including health professionals and social workers as well as fear of a serious diagnosis are recognised deterrents for homeless people’s usage of services.[105, 136, 147, 451-452] P-12: *“Yeah. And I’m very intimidated by...big Doctors... I get very intimidated around them. I start to get panicky and jumpy and can’t breathe. I’ve often been surrounded by Doctors and when they walked out of the room I’ve jumped up, got*

*dressed and ran. That power they have over you...they've the power to make you sick, they've the power to make you well and the power to intimidate you."*

Participants defaulted from treatments either due to fear of investigations (e.g. P-38's fear of liver biopsies) or fear of side effects of treatment (e.g. P12's fear of side effects of HIV treatment.)

Lastly, some participants whose GP was also their methadone prescriber would either avoid attending their GP or revealing health-related issues for fear it might affect their methadone dosage. P-18 (who had a history of suicidality) was afraid to ask her doctor for treatment for her depression as he would put her on daily dispensing in case she overdosed.

## 2. Hopelessness (18 sources/36 references)

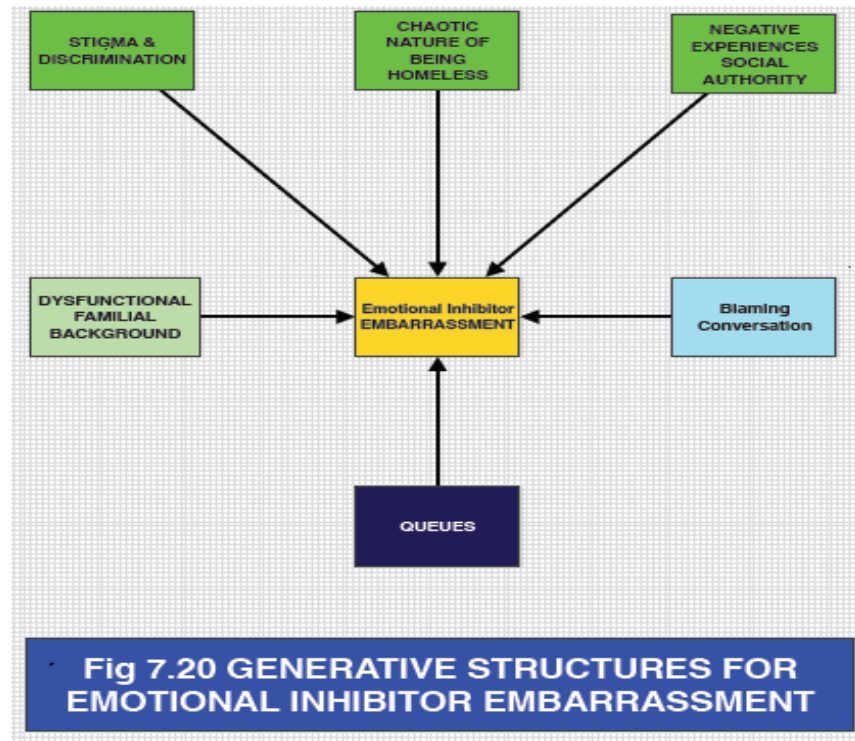


It is recognised that homeless people often feel hopeless; in the control of external forces; and with no optimism as to their future prospects.[487] P-18: *"I don't care about me life."*

Repeated failure instilled a sense of hopelessness. P-7: *"I started back drinking... that's when....I'd probably change into someone else, not necessarily a bad person like but just*

*careless and not care about things, or make appointments and all like ...I'd always be starting fresh somewhere...I'm going to get my shit together and all and then I'd be back to square one in a few weeks."*

### 3. Embarrassment (11 sources/30 references)

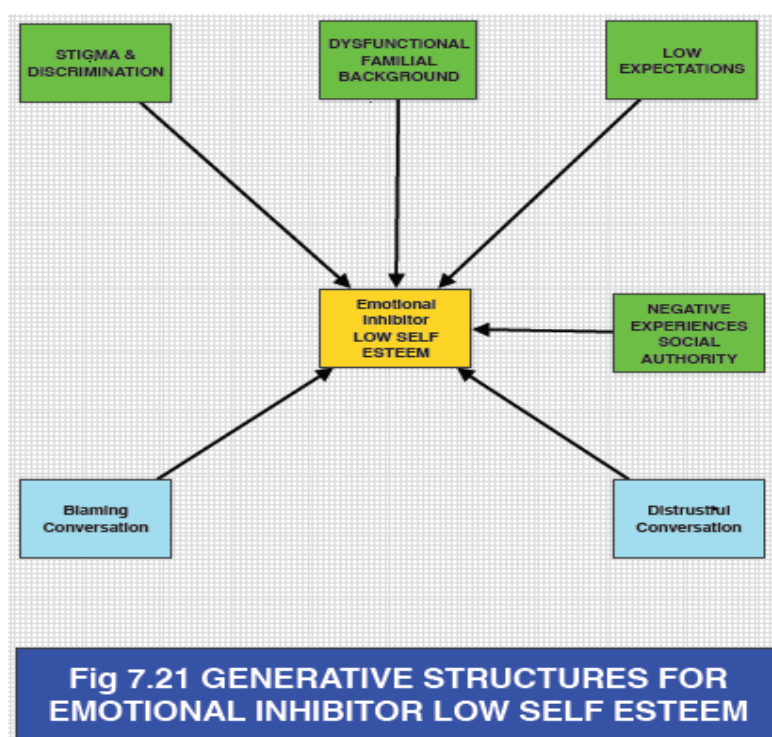


Poor personal hygiene causing embarrassment has been recognised in the literature as a cause for avoidance of health services.[449] P-4: *"There's one thing as well that's made me avoid a few appointments...personal hygiene...any of the hostels you go into...you just wouldn't dare set your foot in any of the showers in there...about an inch thick of dirt in there."* P-6 did not attend with his deep venous thrombosis due to embarrassment at his appearance: *"Yeah, yeah, you know what I mean because I was dishevelled...when you're homeless and in that situation...I was sleeping the street for a week and you can't (go into hospital like that)."*

### 4. Low self-esteem (8 sources/20 references)

Low self-esteem has been identified as one of the major causes for homeless persons' low usage of health services.[468] Stigma has been identified as one of the main causes of low self-esteem in homeless people. FG2P-C did not go to hospital with the clot in his leg due to low self-esteem: *"And along with the stigma sometimes you feel the inferiority complex."*

*I think a lot of addicts have an inferiority complex...I know for a fact that when you go into that hospital, you have all that burden on your back. You know that it's your fault that your veins are as bad as they are, that your breathing is as bad as it is on top of your asthma or whatever...I'm wasting people's time...And I never went to hospitals after that unless when I had no choice -when I overdosed two times after that. You do feel very small within yourself...Never mind the doctors that you feel lower and less of a life form than them. That you leave it that late."*

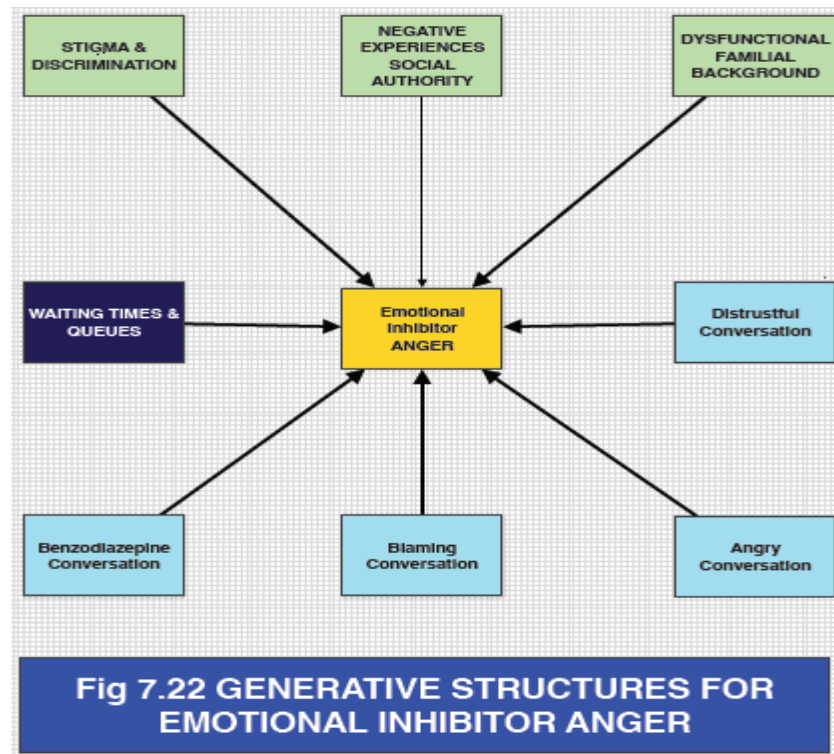


Low self esteem also prevented participants asserting themselves when they felt poorly treated. P4: *“Well I don’t speak up for myself the way other people would.”*

## 5. Anger (8 sources/14 references)

Homeless often end up in arguments with the staff of services they attend including hostels, often becoming aggressive and on occasions violent.[488] Such challenging behaviours have been noted to disrupt their access to health services. Poorly drawn up rules of service can exacerbate this potential for anger and confrontation.[451] FG2P-C: *“Honestly, if I could’ve I would’ve hopped out of the bed and given him a slap. Just a back hand because I’m not a violent person but I honestly wanted to because he was really speaking down to me, even the way he looked at me. He looked at me like a piece of meat*

*and nothing more.”*



## 6. Fearlessness

Lastly, there were some people who seemed to take risks with their health due to having no emotional fear of contracting a serious illness. P-19 was describing to me how his girlfriend insisted on not using protection during sex, despite the fact he was HIV positive: *“She was actually all right about it, like...I explained to (his girlfriend) I’m HIV, Hepatitis C, diagnosed, in prison.....she said to me fair enough.”* I interpreted this using the old phrase, familiarity breeds contempt. In contrast, P-19 described how his girlfriend had a family member and some friends who were HIV positive and doing well so she had become comfortable with the diagnosis. This is consistent with the concept of ‘perceived severity’ as an influence on HSU.

As well as cognitions and emotions that acted as deterrents to HSU, there were cognitions and emotions that were likely to promote HSU when required. Several HSU promoting cognitions existed.

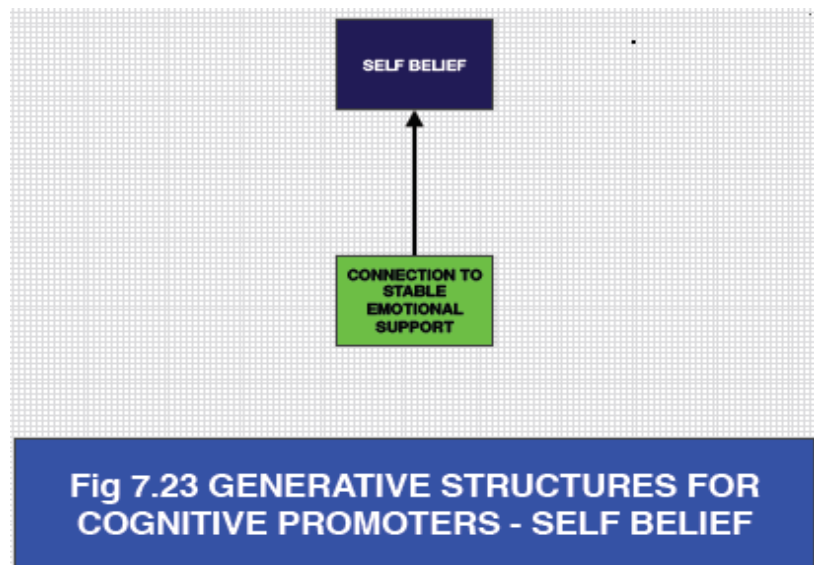
### Internalised Cognitive Promoters.

1. Self belief cognitions



## 2. Presumption of good treatment cognitions.

### 1. Self belief cognitions



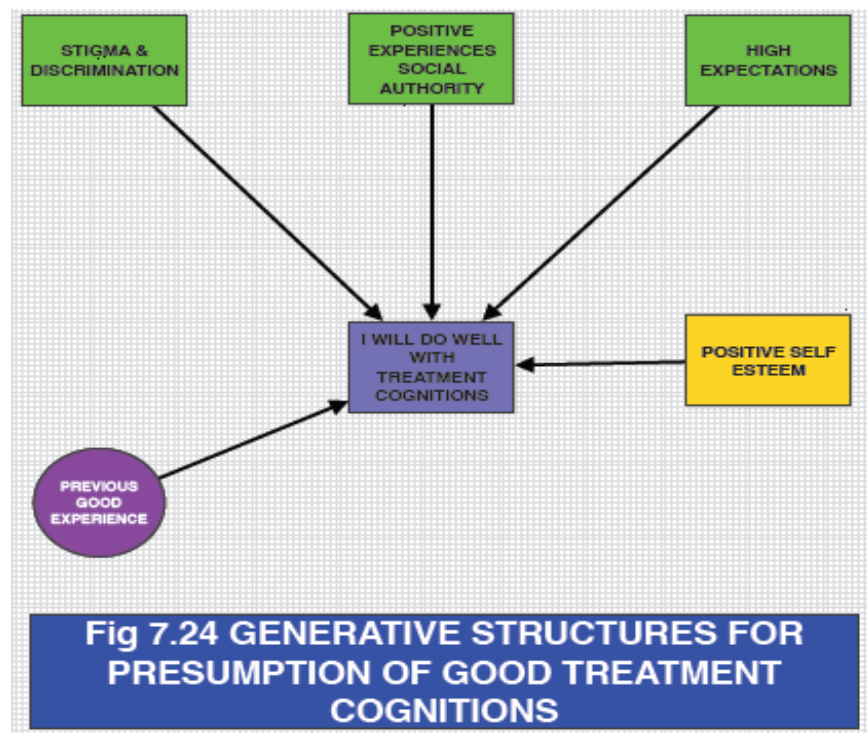
Several participants had a belief or desire to have better health, which they often saw as a precursor to getting their lives together. P-42: *“You have to get your head out of the sand and just keep going and hope for the best. That you will get a place.....get off the drugs first and get the Maintenance and then maybe detox.”*

Over the period of the research P-7 got himself clean off drugs and alcohol and obtained accommodation. He referred to the importance of believing that one can regain one's health and get a better life: *“I got strung out and all but I always knew like...and I always knew with the drink like, that this isn't me like...I just knew I was destined for better things ...I think a lot of it is to do with your head like, cos like if you're feeling crap and you're down on yourself then you're going to start drinking and doing drugs or whatever, so that will leads to loads of health problems like.”*

P-27 noted that once she decided to address her health, she believed there were supports available to help her. Such a belief would increase the probability of addressing one's health conditions: *“It wasn't that hard, because I had help from somebody. Once you're willing to look for the help and stick with the help it is...It's right in front of you...If they go to their Key Worker and say look “I need help”. The help will be given to them.”*

## 2. Presumption of good treatment cognitions.

Participants who had had good experiences in the past with health services were definitely more disposed to going back to those services. For some people, such as P-25, good experiences involved being treated in a professional manner without stigmatization: *“They didn’t treat me any different like...They made sure that I had pain killers and all and they made sure that I was all right and that I was comfortable. And she explained to us step by step like and she didn’t look down on me or anything like that...She was taking extra care with me.”*



For others being treated well was an act of kindness such as experienced by P-9: *“When I was brought into the A&E, one or two nurses that I did know by name...they’d know I had no money on me ‘cause I’m broke, literally all the time. They’d help you out like. They’d get you a sandwich or something hot to eat.”*

Similarly, hearing stories of other people doing well on treatment was a definite promoter for engagement with health services. P-12 had decided to go for his HIV treatment: *“because there is a lot of people out there that’s on triple therapy and they have it since before I was born and they’re looking great. So that’s why I’m starting to go back to the hospital now...One guy told me about how he caught it back in the ‘80’s and he was very*



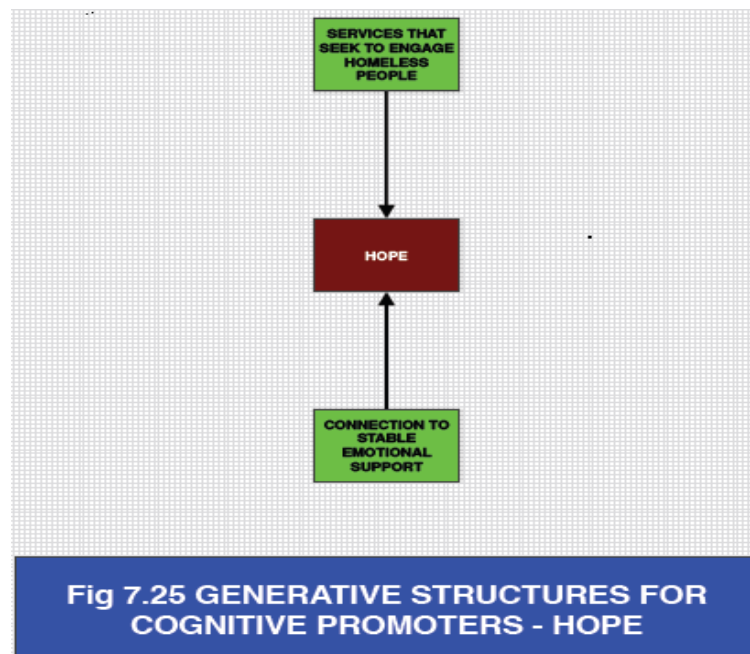
*sick and he got tried on this concoction of tablets and boom.....he doesn't be sick anymore. He wakes up feeling like a normal guy. And I'm noticing my health deteriorating...I need to go for treatment."*

### **Emotional Promoters**

As well as cognitive promoters there were also emotional promoters evident amongst the participants.

1. Hope
2. Anxiety
3. Shame at personal appearance.
4. Trust

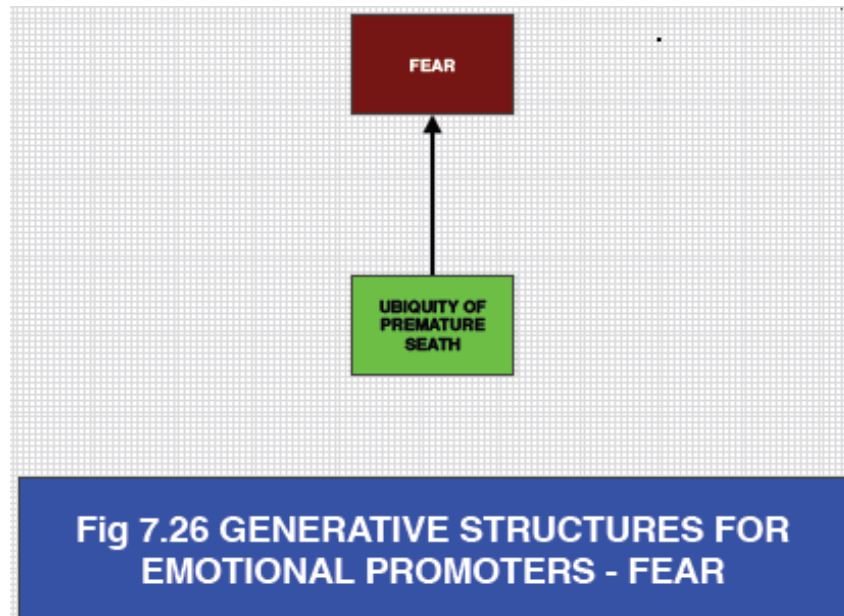
#### **1. Hope (13 sources/ 15 references).**



Just as lacking hope for recovery results in a fatalistic acceptance resulting in non-engagement, having hope is an incentive for engaging. P-30 had hepatitis C. He had not understood that there was a treatment that could eradicate Hepatitis C. When I explained this to him he was delighted and decided to re-attend: *"To be honest with you this is the best news I've had in years.....years. I don't care what I've to do."*

## 2. Anxiety-Fear (6 sources/9 references)

Just as with the housed population, fear of poor health or death is a definite promoter for engagement with health services. P-12: *“That’s when I know, “you’re getting pneumonia, go to the hospital ‘because Pneumonia, people don’t realise, you can die”.*

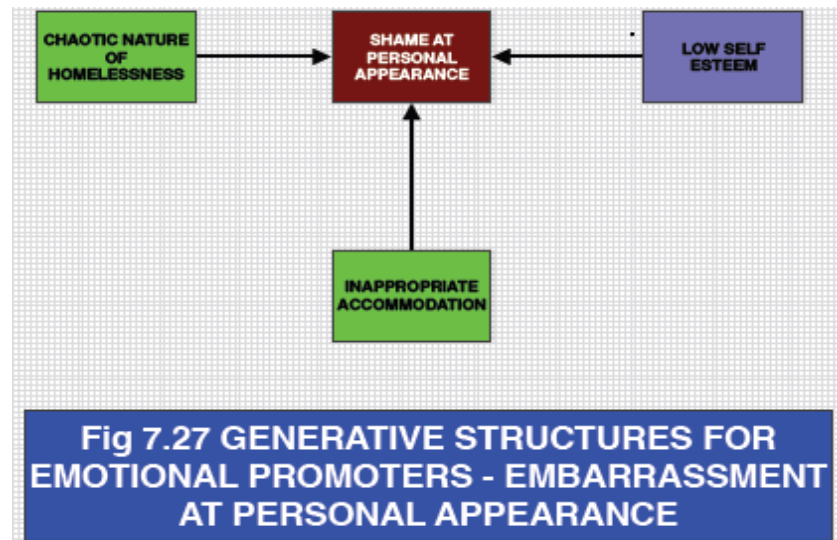


Fear would also cause participants’ partners or family to force them to engage with health services. P-11 described why he insisted on bringing his partner to hospital: *“Because I was worried she was going to get very sick on me. Yeah.”*

Fear was also a promoter for ceasing substance misuse as P-43 outlined: *“I know a girl and she’s after getting jaundice. She’s a very, very, very, heavy drinker.....spirits as well. She’s got jaundice and everything. And that’s what I’m afraid of. I’m determined to get off this drink.”*

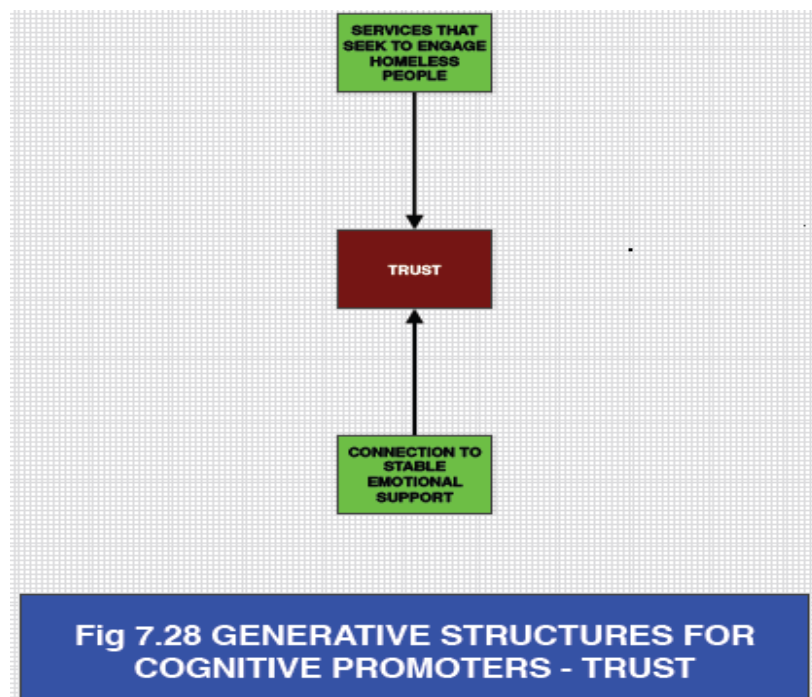
## 3. Shame at personal appearance (3 sources/6 references)

A few clients engaged with health services so as to address health problems that affected their personal appearance and embarrassed them. P-12 was concerned about the effects of weight loss and so engaged with his HIV treatment: *“Now me face is real sunken without them, you know. And I can’t eat and to be quite honest most of me confidence is gone because I’ve no teeth. I won’t walk down the street. The others go “there..(he is)..with a smile on his face” .....not now, no.”*



P-20 was embarrassed at his poor dentition and had gone to get a medical card so he could get a dentist.

#### 4. Trust (16 sources/23 references)



Having a trusting relationship with a health professional promotes engagement.[489] McVP-J felt very intimidated by people in suits. I asked her did that mean that doctors who wore suits terrified her. She replied “*you have a relationship with your doctor and because you've got to know them, you have learned to trust them.*”

### **The effect of Territory on HSU.**

It has been recognised in the anthropological literature that particular groups of people identify particular spaces or territories as having a positive or negative meaning to them.[490] Jones (2013) noted how environment can be owned or not owned by homeless people and this nature of environment affects the ability to engage with the client.[481] A simplistic understanding of space ignores the power-differentials that give meanings to spaces.[492] Wright noted that constructed space for the 'homeless' person is part of the construction of difference between homeless people (us) and non-homeless people (them).[493] Homeless people are known to create their own environments or territories. How comfortable they feel depends on whether the environment is 'theirs' or 'not theirs'

I first became aware of the importance of territory when sitting in the Emergency Department of the Mater Hospital. The waiting area comprises a large area of rows of plastic seating in front of a television. As I sat there a number of people in the waiting area were chatting in small groups of two to five people. Some of them seemed happy. Others seemed to be complaining about the time they have been waiting. I had a sense of people watching each other to ensure nobody would get ahead of them in the queue. Then a woman walked in who was carrying a bottle of coke, she was wearing a tracksuit, her hair was tied back in a pony tail and she looked unkempt. My immediate presumption was that she was using drugs and possibly was homeless. She walked into the toilet and after a few minutes she came out cursing. She was carrying toilet paper which she wrapped around her hand. She started saying "fuckin'...fuckin' this". And then she went up to the front of the waiting room. She was cursing because she was after wetting her clothes in the bathroom. She went up to the heater which was underneath the television and started saying that it was "fucking ridiculous". I felt frightened and just kept my head down. I looked around and everyone else was keeping their head down. No one was looking at her. She started asking if there were any other heaters around. Then she asked for the time. At first nobody answered, they kept to themselves. She said "what's the time?" So I told her "its half 10". And she said "wha'?" And I repeated "half 10". Then she started talking to herself. People were either looking down or up at the TV, in a way that was clear they were not looking at her. She herself looked annoyed and fractious. Eventually a friend of hers walked out from the clinical area. And the two of them walked out. The atmosphere relaxed immediately. I then went out to the front door which is an old archway, with several flights of steps onto a busy main road. I found the same woman and her friend and

five other men chatting. They all looked homeless or drug users. The atmosphere was very different, very convivial, like walking into a party. They were having great fun, cracking jokes, sharing cigarettes (under a no smoking sign) and flirting with each other. The chat and banter reminded me of being in the kitchen at a party. I noted this was their territory where they were comfortable while the waiting room was the territory of the settled non-drug-using community. The co-positioning of homeless and housed people in that territory caused tension and anxiety.

The concept of territory partially explains why homeless people do not like sitting in waiting rooms. P-20: *"Like... I just sort of felt...being in the waiting room with people I'd be thinking like "Ah what are they thinking" – you know. It's like I saw.....I suppose.....me head was like doing overtime...Loads of them do know about my Heroin use like, but it's very hard to hide, especially when you stink of it, you know."*

I also noted the difference in confidence in meeting homeless people in their own environment as opposed to a medical setting. I remember in particular RSTP-1G who used to rough sleep in a well known city centre location and when I visited him would interview me like a barrister and dismiss me when he felt he had enough of me. I subsequently met him when he had gone in to a hostel for a week as he had been suffering from constipation. In the hostel he was more deferential to me and seemed more anxious in my company.

Specialised services are specifically sited within the territory inhabited by homeless people. The Capuchin centre had a very happy atmosphere. People came in and queued for their meal, saying hello to each other and going up and shaking hands. This included both older people who looked like they had alcohol problems or mental health problems and younger people who looked like they had drug problems. It was almost carnival like. At one end of the hall was a small area where people sat on benches outside two surgery rooms. They were queuing for the nurse or doctor and like the others in the hall they were talking and laughing with each other. This seemed a more convivial waiting area than the Emergency Department.

### **How much does homelessness contribute to the HSU of 'homeless' People.**

As discussed in Chapter 2, homelessness is in many ways a constructed notion. It would be useful to disentangle the relative contributions of participants' housing status, addiction

profiles, mental health issues and ethnic background to negative effects on HSU as this would enable more tailored responses to an individual homeless person's lack of access to health services. The effect of homelessness on HSU can be understood firstly, by its direct effect on the external barriers and deterrents and internalised cognitive and emotional inhibitors that affect HSU. Secondly, homelessness has a distilling or exacerbating effect on those other social factors (addiction, mental health and ethnic background) that affect HSU

<b>Table 7.1: Attribution of Source Data relating to factors that negatively affected HSU between Substance Misuse, Mental Ill Health, Ethnic Origin and Housing Status Factors.</b>				
	<b>Substance User</b>	<b>Mental Health</b>	<b>Ethnic Minority</b>	<b>Housing Status.</b>
<b>External Barriers and Deterrents.</b>				
Medical Card	6	6	1	8
Appointments	14	1	0	4
Rules of Service	8	1	0	4
Information	3	1	0	5
Stigma	23	3	1	17
Benzo Conversation.	22	0	0	0
Mistrustful Conversation	14	0	0	4
Blaming Conversation	8	0	0	0
Assertive Conversation	2	0	4	2
<b>Internalised Cognitive and Emotional Inhibitors</b>				
Fatalistic Cognitions	10	5	0	8
Denial Cognitions	11	0	0	4
Presumption of Poor Treatment Cognitions	12	0	0	6
Presumption of Discrimination Cognitions	10	0	0	2
Self-Blame Cognitions	13	0	0	1
Deferral to Future Cognitions	4	1	0	1
Competing Priorities Cognition	17	2	0	15
Fear	17	4	0	18
Hopelessness	14	0	0	5
Embarrassment	3	2	0	6
Low Self Esteem	6	0	0	3
Anger	7	0	0	2
<b>Territory</b>				
Effect of Environment	5	0	0	5
<i>In this table I reviewed the coded data in each of the finalised nodes relating to factors that negatively affected HSU and attributed these individual data to one of the four categories. This process relied on my assessment of whether I felt the recorded data related to participants' substance misuse; mental health; ethnic origin or their housing status. In this process I took account of references to these categories in the data being attributed.</i>				

To identify those factors that homelessness directly affects I created a table where I reviewed the data under each of the factors affecting HSU and attributed the data to either

being associated primarily with the participants housing status, addiction profile, mental health status or ethnic background (see Table 7.1).

Care must be taken in interpreting this table as is imposing a quantitative structure on a qualitative study that did not employ quantitative random selection techniques. However, it serves the purpose of illustrating that homelessness seems to be involved independent of addiction, mental health or ethnic background on most of the barriers, deterrents and inhibitors identified in the study except for those clearly identified as being linked with substance misuse (the benzodiazepine conversations). Interestingly, the blaming conversation seems uniquely identified with addiction. This would be supported by the observation that many charities that work with drug-users and homeless people usually only raise money under the auspices of providing care to homeless people (as this engenders more sympathy and attracts more donations).

The second effect homelessness has is to distil or concentrate the effects of the other factors. Thus substance misuse is endemic in Irish society particularly in impoverished areas. However, those who use drugs can gain some measure of respite by having a home to reside in. Participants in this study talked of the unrelenting exposure to alcohol and drug-use on the streets and in the hostels. It was inescapable. As already noted the deleterious effect of homelessness on mental health and vice versa is well recognised in the literature and documented in this study. Lastly, the negative consequences of stigma faced by ethnic minorities is hugely exacerbated when leaving them exposed on the streets or isolated in large hostels.

Two examples (one from a rough sleeping participant and the other from a participant in a hostel) capture how the generative mechanisms of homelessness, substance misuse and mental ill health work closely in tandem.

RSTP-A slept rough with her boyfriend in the garden shed of an abandoned Georgian House. Her mother had been homeless and she and her siblings had all been in care. She drank a bottle of vodka a day, injected heroin daily into her groin and spent her day tapping on the streets to make money for her drug misuse. She had a history of sub-acute bacterial endo-carditis so injecting heroin put her health seriously at risk. However, she did not care whether she lived or died and was willing to take her chances. She regularly self harmed. I

met up with her during the research and formed a relationship. Subsequently she came to me as a patient. We got her onto methadone, but she did not stop her heroin use as she was drinking and homeless. We gave her an alcohol detox, but it had no effect on her drinking. We tried to get her accommodation, but her drinking and drug usage meant she was quickly evicted. Eventually we placed her in an apartment while starting a methadone and alcohol detox all simultaneously and she managed to stop using, drinking and kept her apartment and stopped self harming for a period of nine months. It was only by addressing all factors simultaneously that we succeeded in addressing all three problems.

I met RSTP-G in a drop-in. I had heard that she had an altercation in a surgery and had called the receptionist a cow. When I asked what was going on she broke down crying and said that she had developed sciatica. She was on methadone. However, as her hostel asked her to leave at 09.30 and stay out till 18.00 she had to spend the day in pain in the local library and she had been driven to take heroin to ease the pain. She said she also was surrounded by heroin users at night. She could see no way out of the vicious circle of drugs and homelessness and was feeling suicidal due to the hopelessness of her situation.

This augmentative effect can also be seen in the interaction between homelessness and aggression/violence. Violence for example has been recognised as impacting on the lives of those living in areas of deprivation.[1] When a person has no home to go to and has to reside on the streets or in hostels with a large number of strangers the level of violence observed and experienced is likely to be more concentrated. This is verified by this research, where the extent of the violence described by participants seemed on occasions not only to be overwhelming but also inescapable as there was no where to find refuge.

Thus as well as having a direct generative effect on homeless persons' HSU, homelessness also has an augmentative or multiplicative effect on the other generative mechanisms i.e. homelessness multiplies the negative effects that substance misuse and mental illness have on the HSU of homeless people.



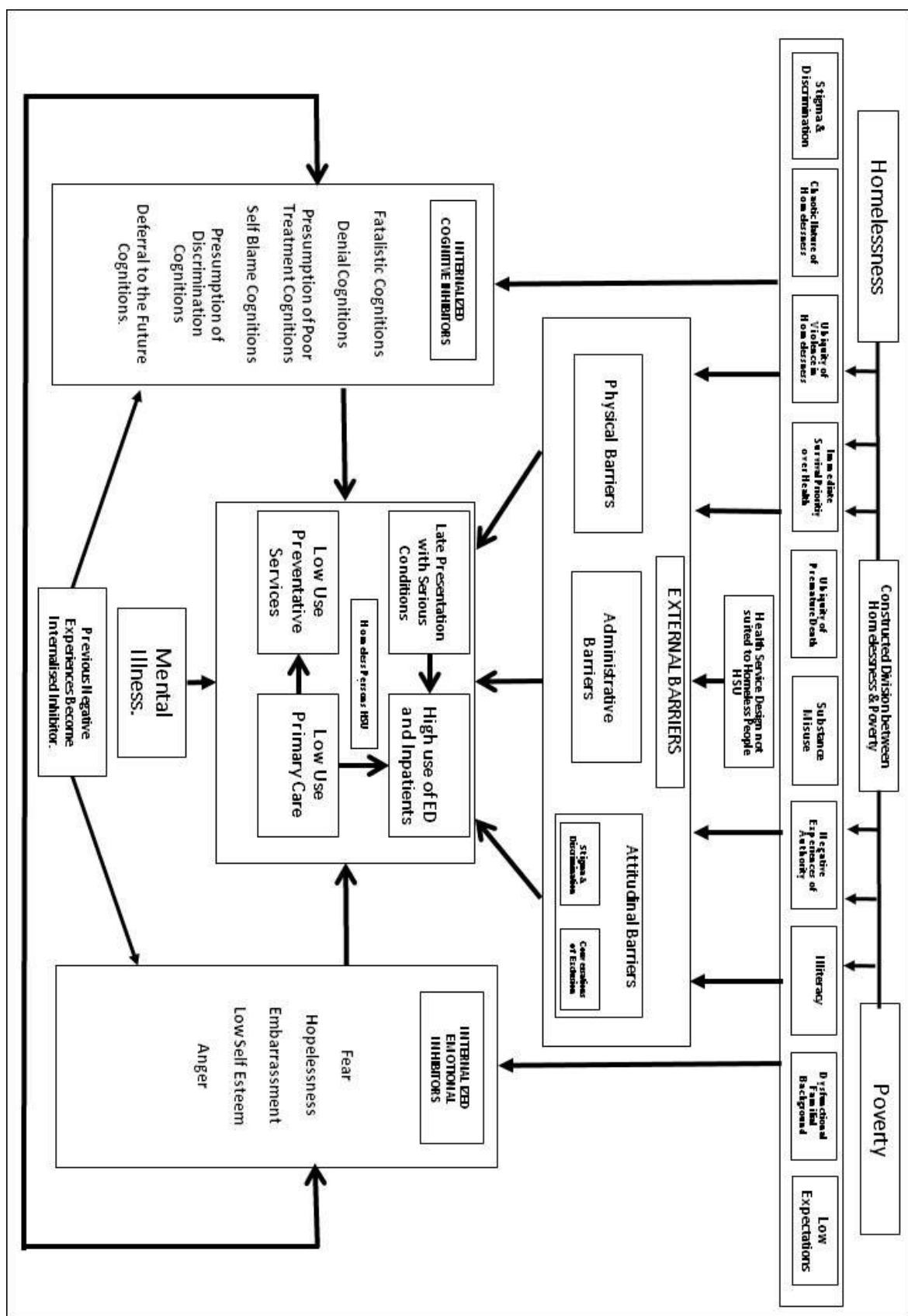
**Critical Realist Explanatory Model for why Homeless Peoples' HSU differs from that of the domiciled population.**

In summary, there is a number of factors which influence each homeless person's HSU. It should however, be understood that rarely does one factor alone explain a particular pattern of behaviour. Often there are several at play concomitantly e.g. having experienced prejudice and discrimination may result in an internalised cognitive presumption that one will always encounter such prejudice and, as this presumption evokes significant anger the person is less likely to use a health service. I collated these various factors into a critical realist explanatory model for why the HSU of homeless people differs from that of the domiciled population.(see Fig 7.29)

This model is designed to show how the generative structures generate or mediate the external barriers and deterrents as well as the internalised inhibitors that affect homeless people's HSU and cause them to behave differently from the domiciled populations. The model is designed to demonstrate how these various elements all interact e.g. external barriers produce both emotions and cognitions which themselves interact to enforce and augment their inhibitory action. The model is not designed to enable the reader to predict a particular homeless person's or homeless population's HSU. It simply seeks to explain the differences in behaviour. However, as such, the model enables identification of areas where interventions may reduce the effect of those barriers, deterrents and inhibitors.

In summary, this chapter outlines a number of external barriers, deterrents & promoters and internalised cognitive and emotional inhibitors & promoters. Using this and the generative mechanisms outlined in Chapter 6 are then used to create a Critical Realist Explanatory Model for why homeless people use health services differently from the domiciled population.

**Fig 7.29 Critical Realist Explanatory Model for why Homeless People use Health Services differently to the domiciled population.**



## CHAPTER 8: DISCUSSION.

*“The life and economic situation of a homeless person appears chaotic from the standpoint of the domiciled citizen, yet the social and economic strategies of homeless people can be understood as the outcome of conscious deliberation and as rational in light of their difficult situation.” [494]*

This research was concerned with making sense of the seemingly chaotic nature of homeless people's Health Service Usage. From the perspective of a domiciled person or health service provider, the HSU often appears as 'inappropriate' and counter-productive. Van Doorn concluded such behaviour is *“not merely the result of chaos and disorder...they have their reasons to make use of certain strategies and reject others.”* [495] When one considers the external and internal barriers, deterrents, inhibitors and promoters, the reasons why homeless people use health services as they do start to become comprehensible.

This research proposes a critical realist explanatory model as to why homeless peoples' HSU differs from that of the domiciled population. (see Fig 8.1) Fitzpatrick offered a critical realist interpretation for understanding the causes of homelessness. She described how the varying ontological positions of positivism, interpretivism and realism approached the question of what causes homelessness. Positivists seek conjunctivist causation, which as Fitzpatrick described, is difficult to identify when it comes to homelessness.[496] Interpretivists contend that 'homelessness' is a constructed concept and that we should ascertain how meaning is attributed to homelessness.(e.g. are homeless people perceived as victims of society or feckless individuals). Jacobs et al noted the construct was *'formed by the power of identifiable groups in society to define a certain issue as a 'problem' that needs tackling in a particular kind of way'*. [497] Pleace maintained that *'there is in truth no such thing as a unique social problem called homelessness and any study predicated on the assumption that it can be isolated and studied in its own right is founded on a misconception'*. [498] All these approaches struggled with the question of whether causation could be attributed to structural or individual agency factors.[496] Fitzpatrick pointed out how in the 1980's analysts started to feel that a purely housing account of homelessness was insufficient and started weaving together

individual and structural explanations together. The resulting orthodoxy made three key assertions:

1. Structural factors develop the conditions for homelessness to occur.
2. People with personal problems are vulnerable to social and economic trends.
3. The high concentration of people with personal problems in homelessness is due to their vulnerability to macro-structural factors.

Fitzpatrick concluded that this new orthodoxy had no clear concept of causation, a weakness which she felt critical realism could address.[496]

In essence, the development of explanatory models for the HSU of homeless people evolved similarly. The Gelberg-Andersen model (Fig 8.2) and Penchansky & Thomas's 'barriers to access' model sought to create a similar weave between structural and individual agency influences on the HSU of homeless people though the emphasis on structure and agency as causative agents differed in the patterns they created.[164, 299] Gelberg & Anderson incorporated the concept of vulnerability into their model.[164] It is proposed here, that as with the causation of homelessness, neither of the two previous models had clear concepts of causation and that the critical realist model proposed in this study can address this weakness.

Prior to articulating how this model addresses causation differently to the other models, it is important to point out that, unlike the Gelberg-Anderson model which seeks to be both explanatory and predictive of the HSU behaviour of homeless people and the Penchansky & Thomas model which seeks to explain why people may find it difficult to access services through a categorization of potential barriers, the critical realist model proposed by the current researcher seeks to explain why homeless peoples' HSU differs from that of the general population i.e. it does not seek to explain or predict their HSU *ab initio*. The purpose of this approach which focuses on explaining the difference in behaviours is that the comparative process between the general and homeless populations HSU augments the retroductive process, in that explaining differences in behaviours is easier than explaining those behaviours without any reference point. For example, queues can be identified as a deterrent to any person, homeless or housed. Many people would criticize others for not staying in queues and waiting like everyone else. However, when one considers that, unlike most domiciled people, homeless people worry about their

hygiene; can go into withdrawals; have other survival priorities; and are affected by stigma that domiciled people do not experience, one can understand why homeless people are less likely to remain in a queue. In a sense it is similar to exploring health inequalities where, rather than seeking to understand why a population has a particular mortality or morbidity rate, one seeks to understand why those statistics vary so much between differing socio-economic groups.

This critical realist model differs in two ways from the previous models when seeking to address causation. Firstly, it seeks to identify generative mechanisms that explain the HSU tendency of homeless people. Critical realism recognises how homeless can be a constructed concept that has an underlying reality. This study reflected this constructed nature of homelessness in that participants were from many different populations (including drug users, alcohol drinkers, people with mental health problems, ethnic minority communities and economically homeless) but that findings which were specific to some of these sub-groups were of no relevance to others. However, the study further identified a reality to the HSU behaviour of homeless people in that the behaviours identified here replicate the HSU described in other international studies. This consistency of findings improves validity and indicates that the seemingly chaotic behaviour has some coherent rationale. The research identified several generative mechanism rooted in the socio-economic circumstances from which homeless people came; the effect of poor mental health; and the nature of homelessness itself.

Secondly, the model proposed here places more emphasis on structural determinants of behaviour than the other models. The manner in which the models differ in their emphasis on individual agency versus structural generative mechanisms as explanations of homeless peoples HSU is critical in determining how we can improve homeless people's HSU. For solutions that focus on individual behaviour are likely to fail if the behaviour is determined by structural generative mechanisms. In medical parlance, we would be treating the symptom and not the cause.

The Barriers to Access model predominantly focuses on structure. It contends that homeless people face barriers to access that are determined by the five A's (Availability, Accessibility, Affordability, Accommodation and Acceptability). The first four of these refer to structural issues while the fifth (acceptability) emphasises individual agency. [302]

The Gelberg-Anderson model similarly disperses causation between individual and structural factors. [300] However, the emphasis is strongly placed in individual factors. The model identifies a vulnerable domain which refers to marginalised groups – the implication of vulnerable meaning that it is the individual who is responsible for being excluded, whereas another term e.g. marginalised would imply societal structures are responsible.

Table 8.1: Gelberg Anderson Behavioural Model for Vulnerable Populations.[164]				
Predisposing Factors →	Enabling Factors →	Need →	Health Behaviour →	←←Outcomes
<b>Traditional Domain</b> <b>Demographics</b> Age Gender Marital Status.  <b>Health Beliefs</b> Values Concerning health and illness Attitudes towards health services. Knowledge about disease  <b>Social Structure</b> Ethnicity Education Employment Social Networks Occupation Family Size Religion	<b>Traditional Domain</b> <b>Personal Family Resources</b> Regular Source of Care Entitlement to free primary care Income Social Support Perceived Barriers to Care  <b>Community Resources</b> Residence Region Health Services Resources	<b>Traditional Domain</b> <b>Perceived health</b> General Population health conditions  <b>Evaluated Health</b> General Population health conditions	<b>Traditional Domain</b> <b>Personal Health Practices</b> Diet Exercise Self Care Tobacco Use Adherence to care  <b>Use of Health Services</b> Ambulatory Care Inpatient Care Alternative Healthcare Long-term healthcare	<b>Traditional and Vulnerable Domains</b> <b>Health Status</b> Perceived Health Evaluated Health  <b>Satisfaction with Care</b> General Satisfaction Technical quality Interpersonal aspects Coordination Communication Financial Aspects Time spent with clinical Access / Availability Convenience Continuity Comprehensiveness Administrative Hassle
<b>Vulnerable Domain</b> <b>Social Structure</b> Country of birth Acculturation / Immigration / Literacy Sexual orientation  <b>Childhood characteristics</b> Residential History (e.g. foster care, orphanages) / Homelessness Living Conditions Mobility (stability of home) Length of time in the community Criminal behaviour / Prison history History of abuse or neglect Mental Health Psychological resources (self esteem, social skills etc) Substance abuse	<b>Vulnerable Domain</b> <b>Personal Family Resources</b> Competing Needs Hunger Social Benefits Self Help Skills Ability to negotiate system Key worker Transport Telephone Information Sources  <b>Community Resources</b> Crime rates Social Services resources	<b>Vulnerable Domain</b> <b>Perceived health</b> Vulnerable Population health conditions  <b>Evaluated Health</b> Vulnerable Population health conditions (e.g. TB, STD's, and HIV, Hepatitis etc and substance abuse and mental health problems).	<b>Vulnerable Domain</b> <b>Personal Health Practices</b> Food sources Hygiene Unsafe sexual practices	

This critical realist model identifies many individual agency factors describing them as cognitive and emotional inhibitors and promoters. However, while cognitions and emotions exist at the individual agency level, within this model, these cognitions and emotions are identified as emanating from structural generative mechanisms. It is recognised in the literature that cognitions and emotions affect human behaviour, including health behaviours, though the level of influence is variable. [499-503] The cognitive

inhibitors described here have not been so described in the literature. Emotions are identified as affecting HSU behaviours, but not within a conceptual framework of inhibitors. The concept of these cognitions and emotions being ‘internalized’ from the external world exists within the literature in relation to ‘internalizing ‘ stigma, but not to the other cognitions and emotions identified within this research. This internalization is part of the process whereby the generative mechanisms take effect at the individual level e.g. the high level of death in homelessness is experienced by homeless people through deaths of their friends and often siblings. This results in them internalising a fatalistic cognition of ‘why bother attending a health service if I am going to die young’.

This shift of focus from individual agency to structural causes as generative mechanisms is noticeable in several other areas. Competing needs are described in Gelberg & Anderson’s model under the personal vulnerable domain. In this current research, the concept of competing priorities is re-interpreted as immediate survival being prioritised over HSU.[2, 164] The reason for this was that participants identified these other priorities as being essential to immediate survival. Everyone would recognise the importance of obtaining shelter, food and welfare as important to survival. Obtaining drugs or alcohol may not adhere to societal perceptions of ‘need’; yet there is a reality that those who are addicted to substances will go into physical and psychological withdrawal. The concept of ‘competing priorities’ leaves it open to interpretation that homeless people may have ‘got their priorities all wrong’. Framing ‘competing priorities’ under the generative mechanism of immediate survival being prioritised over health enforces the point that immediate survival is an ever-present concern for homeless people and points ultimately to structural causation as opposed to individual vagary.

Gelberg & Anderson’s model refers under the vulnerable domain to the concept of ‘ability to negotiate the system’ which places emphasis on individual agency.[6] The critical realist model does not refer to this, but rather identifies this as a structural issue under the concept that mainstream health service design is unsuited to the HSU of homeless people. It is recognised that services may be inequitable in the manner in which they are organised so proving unacceptable to some members of the community.[164, 302]

Another factor whereby structural generative mechanisms produce tendencies at the individual level was Conversations of Exclusion. While some of the elements of these

conversations have been identified in the literature, (but not related under the conceptual framework of ‘conversations of exclusion’) the descriptions of the complete interactions are new to the literature. It has been estimated that between 15-30% of doctor-patient interactions can be classified as ‘difficult encounters’. Such encounters leave both doctors and patients frustrated. Identifying the factors that result in difficult encounters can only serve to improve physician morale and patients experience of healthcare.[504] A conversation of exclusion is an interaction between a health service provider and a service user where, due to the participants in the interaction have differing underlying assumptions as to the nature of the interaction, the conversation deteriorates into a negative interaction that results in the user being excluded or excluding themselves. Exclusion from a medical service is the ultimate sanction and has been shown to be deleterious to health.[463, 466-468, 505-506] There is an extensive literature written on the importance of the doctor-patient relationship and how communication skills positively influence such.[507-509] There is also literature that explores how the differing social class background of healthcare providers and patients can affect the doctor patient relationship. Providers are more likely to have negative conceptions of lower socio-economic patients’ personalities, abilities, behavioural tendencies and potential for substance misuse. These perceptions have been demonstrated to negatively affect healthcare providers’ behaviour with such patients, including giving less information due to the presumption that patients from lower socio-economic backgrounds have less understanding of health issues. Patients who are perceived to be deviant are in particular prone to be affected by negative behaviours resulting from such healthcare provider attitudes.[510, 511] The fact that that certain doctors and patients could negotiate such conversations in a manner which did not cause breakdown in the relationship suggests the possibility of developing communication skills or approaches that do not result in exclusion.<sup>15</sup>

Thus, ultimately this model ascribes causation to structural generative mechanisms. The only individual factor that is not ascribed to structural generative mechanisms is mental health. This emphasis placed on structural factors as generating the HSU tendency of homeless people is important as Levesque noted structural obstacles are more responsive to health policies than population characteristics.[10] Further it prevents the stigmatization of homeless people as being responsible for their own situation.

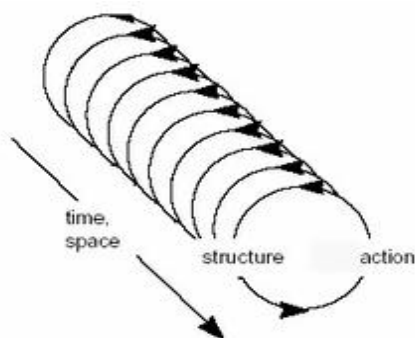
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<sup>15</sup>I have developed such skills for the Benzodiazepine Conversation and have been teaching them to GP registrars for the last number of years.



This critical realist model also identifies a model for how structure and agency interact. Critical realism approaches the structure-agency debate by perceiving them as separate entities which are relational and exist only through interaction between agents.[338] Choby & Clark contend that critical realism has not developed a satisfactory explanation for how structures that arise from individual choices rebound on the individuals to create inequality.[512]

Structuration theory does address this particular question and has been used within a critical realist framework as it views people and the social institutions they create as social constructs.[512-513] In Giddens's structuration theory, agency and structure are an inter-related 'duality' rather than separate entities. Structure is created by individual actions while at the same time it orders that same action. Social systems refer to reproduced 'routinized' practices whereas social institutions refer to reproduced rules and resources. Structures can be enabling or constraining, but due to the fact that they arise from the action of individual agents, they offer the possibility that those same agents can bring about change in those same structures.[514-515] Giddens suggests that individuals adopt social practices and institutional rules through an internal reflexive process both at a subconscious level constituting practical everyday knowledge and at a conscious level where they review their world in a discursive manner. Rules adopted at a subconscious level are continuously enacted automatically. Those that are reviewed at the discursive level become 'knowable' to the individual and, as a result, offer the potential choice to exercise individual agency in contradiction to the structural rules.



**Fig 8.1 Structuration duality of structure and agency over time and space.[516]**

This research outlines a conceptual model where individuals adopt the social practices at a subconscious level through the internalization of (i) external realities (e.g. the high rate of young death in homeless people); (ii) external social attitudinal messages (e.g. substance misusers are to blame for their predicaments); and (iii) external behavioural messages (e.g. homeless people will not be signed up by local doctors) into a cognitive and emotional matrix that generates a particular HSU behavioural tendency. This approach echoes Baber's query as to whether Giddens over-emphasizes the individual's capacity to shape his/her social structure. The over-powering nature of social and institutional practices encountered by homeless persons, coupled with their absolute dearth of allocative and authoritative resources, would seem to severely constrain their individual agency.[517]

Interestingly, Giddens also refers to 'time and space' where different rules may apply. He notes how, in differing spaces, individuals' have to renegotiate their position in a process he termed regionalization of activity. In this research, it was identified that territory had an influence on participants' HSU behaviours. The waiting room in the hospital had two territories, one in the room itself and the other outside the entrance where homeless peoples' social positioning significantly differed.

The identification of mainstream services as not being suited to homeless peoples' HSU behaviours has implications for the delivery of health services to this population. Specialised services are specifically designed to suit the HSU of homeless people. Preece commented that "services have obviously been developed or modified to counteract the known attitudinal and organizational problems that were blocking access to the NHS for homeless people." [518] They are delivered in locations accessible to homeless people; they do not require appointments; staff are trained to engage with homeless people and to deal with challenging behaviours; services are tailored to the specific health needs of homeless people e.g. the provision of substance misuse treatments, hepatitis B vaccination, TB screening etc. These services are undoubtedly favoured by homeless people.[38, 39] There is also significant evidence that such services improve access to health care for homeless people both internationally and in Ireland.[167, 302, 519-521] They have also been found to reduce attendances at ED.[522] When offered as a part of a multi-faceted response 'specialised' health services can help offer a route out of homelessness.[35]

There have been significant and influential criticisms of specialised services in particular the argument that they result in the segregation of homeless people into parallel services, thereby further marginalizing them.[92, 523-524] Riley et al felt that such services created a potential to 'ghettoize' health care for homeless people. They argue that we should concentrate on making mainstream services more accessible to homeless people.[525]

Further, there is a paucity of evidence supporting the notion that such services may have significant impact on the health of homeless people.[302, 526] As one US study notes 'the use of [specialized health service] care may not have a major impact on health outcomes for the homeless, given the harshness of their environment and the current state of healthcare available to them'.[527] Of note, this assertion is not an argument relevant to the 'mainstream' versus 'specialised' debate as it could equally apply to mainstream services. If, for example, we do not improve the living conditions that homeless people have to cope with, we have no chance of improving their health status however we deliver health services. The fact that health services have little success in improving health in comparison to improving social conditions is not new to us.[527] Ireland has adopted the 'social inclusion' approach to health which seeks to make health services accessible to all. In this model specialised services are viewed as temporary services while the mainstream services are made more inclusive.

This research suggests that while making mainstream services is attractive in principle, it would require such extensive reorganization of the health service and reduction in the stigma faced by homeless people as to be pragmatically impossible. Thus, specialised services for homeless people are required until such time as we eradicate homelessness or significantly alter the nature of homelessness and in particular address the generative mechanisms that produce the HSU of homeless people.

As noted in the research, the present health services seem to be influenced by a number of factors. Firstly, they conform to the HSU of the domiciled population who are more likely to favour the continuity of primary care services prior to hospital specialists[527]; present early on in the course of their illness so preventing late presentations to secondary care[528]; avail of preventative services offered in the primary care and public health systems.[528]; tend to use the ED for emergency services only[529]; tend to keep appointments[530]; and will either comply with waiting times or use private health

services to shorten waiting times.[531. 532] Secondly, they are driven by the need to deliver cost efficient services. Primary care services act as a filter prior to secondary care services (in particular ED) which results in a more effective and efficient health service.[533, 534] Since secondary care services such as ED, OPD and, in particular, inpatient treatment are much more costly than primary care services, it is cost efficient if people obtain treatment for their health conditions in order to pre-empt the need for secondary care.[532, 534]

A service designed to suit the HSU of homeless people would be different. It would need to be located in homeless peoples 'territory'; not be appointment based; have flexible hours; have measures to prevent withdrawals while waiting; have creative responses to queues (e.g. having a meal while waiting as happens in Capuchin Centre; receive key-working as happens in MQI); such a service would have the means of ensuring that homeless people follow up for both treatment of their illnesses and preventative health-care; have staff with the skills to engage with those homeless people who mistrust health services and the skills to manage challenging behaviours; have simplified administrative systems (that address needs of those who are illiterate) and support for those who have no interest in filling in any forms; and have the range of primary care, secondary care, psychiatric and substance misuse treatment services necessary to treat the particularly poor morbidity profile of the homeless population. In addition, it would need to be accessible to them, during episodes when they temporarily escape homelessness. One would have to ensure that all health services encountering homeless people would conform to these new requirements.[535, 536] In addition it would need to be taken into account that that waiting rooms of health services can be perceived as external to the homeless person's territory and this can deter them from accessing such services.

As well as redesigning health services, one would have to address issues of stigmatization and discrimination against homeless people and substance mis-users within primary and secondary care services as these have been identified by some authors as the main barrier to accessing services for homeless people.[520] In Ireland the huge difficulties in getting GP's to offer methadone treatment to substance mis-users (despite the generous reimbursements on offer) is well recognised.[537]

Lastly, one would have to address the factors that affect homeless people's HSU but which are independent of the health services. These includes their survival priorities; their internalised cognitive and emotional inhibitors (including low self-esteem); and the tensions that create the benzodiazepine, mistrustful, blaming and angry conversations which occur between health professionals and homeless people.

The findings from the study support striving to achieve the changes described above. However, unless we address the generative mechanisms identified in this research, we have little hope of making mainstream services sufficiently accessible to suit the HSU of homeless people. Some of these mechanisms such as mental health are outside society's ability to change. Thus, it is highly probable that there will be a permanent need for specific services that can reach out to those on the margins. If, as Wright felt, accessible primary healthcare services are a prerequisite to effective health interventions, then we should continue with those services that we know homeless people currently access.[92]

Central to the concept of parallel services stigmatizing homeless people by segregating them from 'mainstream' services is the notion that such services are separate to mainstream services. An alternative conceptualization of 'specialised' services is to recognise that the health sector offers services to many differing communities who have differing needs and differing HSU behaviours. If we want to ensure that the population as a whole has access to healthcare we need a health system that has the flexibility to take these differing needs and HSU behaviours into account. Lester et al argued that specialised and mainstream services should be combined e.g. a rough sleeper could register with a specialised service to address his/her immediate health needs and then transfer to a general surgery.[523] Services designed to meet the needs and HSU of homeless people are required, as are services to meet the needs and HSU of elderly people; business people and workers who cannot make daytime surgery hours; substance mis-users, disabled people, members of the travelling and Roma communities; families with young children; migrants etc. Some of these groups will require tailored adaptations to ensure they will access the full arsenal of health interventions available to meet their needs. By integrating such services into the mainstream general services, patients attending these services will be able to access the full benefits available within the general services.

As an example, in Dublin, specialised primary care services are seen as separate from the mainstream services. They are provided by independent GP's who work in the hostels and nurses who are employed by voluntary organizations working with homelessness. As a result users of these specialised services are not allowed access to mainstream primary care services such as community physiotherapy, dietetics, occupational therapy etc. If health services were reconfigured according to the model of healthcare provided in Oxford (as an example) they would be able to avail of all the services available to any NHS patient. In the Oxford Primary Care model, homeless patients are registered as an NHS patient with the specialised primary care service. This service has extra resources to provide a higher doctor and nurse patient ratio as well as access to specific addiction and mental health workers. Homeless patients are to all intents and purposes the same as any NHS patient, but have tailored services within their primary care centre. When, or if, they exit homelessness, they are encouraged to register with another primary care centre although, in recognition of the relationships they have with the medical staff, as with other practices serving homeless people, they may remain attending for up to one year.[518] Kertesz et al recommended the establishment of such a service with a blend of multi-disciplinary health professionals, outreach workers and mental health and addiction support workers as a tailored model for homeless people.[173] Interestingly, the disabled community has long fought against the term 'special' services as they maintain state services should provide a range of services for different needs without labelling one group as being different or deviant from the 'mainstream'. We should think of primary care services for homeless people as just being amongst a range of mainstream services required for differing needs.

Some of the findings from this study were either new to the literature or formulated differently to how they are presented in the literature. The generative mechanisms ubiquity of premature death; ubiquity of violence; and low expectations due to poverty are described in the literature but not considered as possible influences on the HSU behaviours of homeless people. The concept of Conversations of Exclusion and the actual conversations described under this concept are unique to the literature. The barrier created by ineffective management of addiction withdrawals in ED is not referred to in the literature.

Findings that were not new but presented in a conceptually different framework include the differentiation of firstly, external barriers, deterrents and promoters and secondly,

internalised cognitive and emotional inhibitors and promoters. The literature frequently refers to barriers to HSU for homeless people and on occasions deterrent or facilitators.[164, 538] However, the differentiation and definitions of barriers, deterrents, inhibitors and promoters adopted here are new to the literature. In this research external barriers and deterrents were defined as different entities. The fact that homeless people with addictions will avoid attending ED due to the expectation (created by their own or another person's related previous experience) that they will not receive medication to prevent withdrawal is also not alluded to in the literature. This may be because it is a phenomenon that is unique to Dublin.

This research also identified new generative mechanisms why homeless people's HSU differs from those who are domiciled. Some of these have been identified as part of the causal chain for homeless people's HSU in the literature, but not within a critical realist model. For example, substance misuse has been identified as a negative influence on homeless people's HSU but not identified as a generative mechanism within a critical realist framework.[53, 147, 539] Critical realist research has also identified generative mechanisms for homelessness that are identified here as affecting HSU as well. Both poverty and familial dysfunction are recognised as causing homelessness, but their role in producing the HSU of homeless people has not been described.[512, 540] The concept of poverty causing lower expectations exists within the literature, but in relation to educational achievement rather than HSU.[407] It is well recognised that early death is ubiquitous and for homeless people death 'could always be just around the corner'.[434] However, I could find no reference to the effect of this on homeless people's HSU. Likewise, the pervasiveness of aggression and violence within the homeless world is well recognised, but its effect on HSU has not been highlighted.[89, 541]

In summary, this research introduces new findings and new concepts into the literature on Health Service Usage of homeless people. The implication of these findings is that tailored services for homeless people are a pragmatic necessity and we should develop them as part of the mainstream's range of services for patients with differing needs. The research produced a Critical Realist explanatory model for why homeless persons' HSU differs from that of the domiciled population. This model suggests individual agents replicate social structures through internalizing cognitions and emotions that arise due to social mechanisms at the generative level.

## **CHAPTER 9: CONCLUSIONS.**

This research sought to make sense of the chaos of street/hostel life and how it affected the HSU of homeless people. Once one understands the raw and chaotic nature of street and hostel life, the HSU behaviour of homeless people can be understood as both a prioritization of behaviours that arises from the imperative to survive; the necessity to negotiate external barriers and deterrents; and the influence of internalised cognitions and emotions formed within the context of the background that caused them to become homeless or in the nature of homelessness itself.

### **Implications for Policy & Practice.**

This study offers a number of possible implications for practice and policy in order to address the factors that prevent homeless people availing of the advantages of the health system. This is particularly important in light of their poor health indices.

At a policy level, it suggests that the factors that generate the HSU behaviour tendencies of homeless people are rooted in the social policies that create the unequal distribution of wealth and the conditions that produce poverty. Addressing these issues requires political will to address the root causes of social inequality.

Housing policy is also critically connected to how homeless people use health services. Having to rely on insecure accommodation exposed participants to a series of factors including the need to prioritise immediate survival; being exposed to the threat of violence; and learning to cope with the chaos of homelessness. All these factors contributed to their ineffective HSU. In addition, crowded hostels placed participants in significant danger of violence and were often avoided in favour of rough sleeping, due to fear of such violence. Housing is critical to the proper management of health and policy-makers need to create solutions that enable homeless people obtain secure long-term, appropriate accommodation in a timely fashion. Housing First models whereby homeless people placed in houses (as opposed to temporary hostel accommodation) with high support networks, seek to provide such a solution and have been found to improve engagement with health services.[518] In addition, the policies of denying homeless people who come from outside the Dublin area access to long term accommodation should be reviewed in light of the potential effects on health and access to healthcare.



Health policy makers should recognise that all administrative processes create barriers and it behoves the creators of those processes to simplify, literacy proof and ensure as much as possible that the process can be easily accessed and completed. The medical card application process is an example of where simplification, literacy proofing and easy access and completion could prevent homeless people from losing their entitlement to free primary healthcare. It is further suggested that this process of reducing the barriers created by administrative processes should be considered as a marker of quality and subject to audit. The concept of 'quality' in health care should include the concept of access i.e. an inaccessible service should not be deemed to be a quality service.[542] Equity audits could be designed to assess the accessibility of services as part of a quality initiative to address barriers and deterrents.

The issue of stigmatization and discrimination by health professionals against homeless people needs to be addressed at a policy level. Pauly argues that policy makers ignorant of this issue have served to disenfranchise those on the street seeking healthcare.[543] At present it is unclear whether equality legislation applies to medical institutions and health professionals refusing to treat groups such as homeless people or drug misusers.[544] Nor is it clear if Irish medical professional codes of practices tolerate such discrimination. The Irish Medical Council does not explicitly say discrimination against such groups is unethical[387] The British code in contrast advises against discrimination based on patient life choices or on patients contributing to their conditions; the New Zealand code advises against discrimination of patients; while the Canadian code advises against discrimination based on socio-economic status.[545, 546] Such discrimination needs to be tackled at a political and medical ethics level both to allow redress for those affected and also as a message as to the impropriety of such discrimination.<sup>16</sup>

Stigma and discrimination can also be addressed in medical and nursing education. In addition, undergraduate and postgraduate medical curricula need to address the issue of

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<sup>16</sup>I have developed a campaign to firstly, lobby Irish Medical Council to produce clear statements describing discrimination against marginalised groups as being unethical and secondly, to incorporate methadone prescribing into routine general practice provision as part of the Department of Health's negotiations on a GP contract.

stigma and discrimination against homeless people.<sup>17</sup> I have founded a GP training programme (the North Dublin City GP Training Programme) which specifically trains GP's to work in areas of deprivation and with marginalised groups. As part of their fourth year studies trainee GP's have to work one day a week for four months with drug users; one day a week for four months in prisons and with ethnic minorities; and one day a week for four months with homeless services. This module was inspired by the Contact Hypothesis which contends that contact between differing groups facilitates learning about the other group and the knowledge derived from this reduces prejudice.[547-548] Many studies have now confirmed the validity of this theory including one meta-analysis of 515 studies involving a quarter of a million people.[548]

At practice level there are a number of implications: The application of rigid rules acts as a barrier for many patients from marginalised groups. The barring of people often results in those who most need a service being denied access to that service. These rules and barring procedures often arise from the need for institutions to ensure smooth running and also to manage safety for staff. As Poland et al noted "often therapeutic demands (care) and safety imperatives collide." [549] Karabanow and Rains found that where rules were strictly applied in the interests of safety, the clients of the service interpreted the application of those rules as uncaring.[550] Oudshoorn et al noted the tension between the need for safety and the provision of healthcare and how behavioural controls to improve safety often resulted in lack of access to health services for clients. They found that clients and service providers often had different conceptions of safety due to their differing backgrounds and experience of aggression and violence. They recommended reflection on what is an acceptable level of risk in a healthcare setting.[551] I propose the exploration of a concept of 'high-fidelity' services whereby services seek to remain in contact with clients. Such an approach would mean that in situations where clients or patients break rules thereby resulting in risk to staff or other patients / clients, actions be devised to ensure that clients know that while there are consequences to their actions, the service will still meet their needs. Such responses could include a range of options: getting the client to recognise the risks they have created and devising a plan to address those behaviours so they will not recur; seeing the patient in a different location; transferring the patient to a similar service

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<sup>17</sup>I have been involved in including this issue in the Irish College of General Practitioners draft curriculum for GP trainees.

elsewhere temporarily; even barring the client from the premises where the service is provided but using outreach to continue providing the service.

Secondary care services should review their management of the substance misusing patient who is awaiting treatment, but potentially going into withdrawals so as to ensure that such withdrawals do not result in patients being denied necessary treatments for their health conditions. As a doctor I would recognise the difficulties created by this issue where patients can mangle in order to obtain drugs for alcohol or heroin withdrawal. However, these difficulties do not justify ignoring a real barrier to the delivery of healthcare.

Specialised services are recognised as adopting the low threshold approach which was originally developed in drug services. Thus, services aim to be open and accessible to all people in society and in particular to those on the margins. They aim not only to reduce barriers and deterrents but to actively seek to engage reluctant clients into their services. I propose that specialised services also display 'high fidelity'. High fidelity entails being faithful to every client that enters one's service and seeking to retain them. Thus, efforts would be made to reach clients who have disengaged. High fidelity services also manage challenging behaviours in a manner that retain clients – this is achieved by helping clients calm down and deal with their frustrations in a non-violent manner. Even in the most aggressive incidents clients can be either temporarily transferred to another service or work with outreach while being temporarily banned from the building. Specialised services should actively promote the concept of low-threshold/high-fidelity service as a model for all health services.

### **Suggestions for Further Research**

Firstly, similar research could be conducted at other sites to identify if similar or further external barriers, deterrents and promoters and internalized inhibitors and promoters can be identified. In addition, the research could seek to identify if similar or different generative mechanisms are influencing the HSU behaviour at these different sites. Such research would enable us to know whether findings from this research can be transferred and generalized as well as test out the validity and applicability of the critical realist model proffered here in other settings.

Secondly, the generative mechanisms suggested in this research were devised using a retroductive 'best fit' approach. As such, research could be done to explore the validity of

the results of this retroductive approach and whether the identified generative mechanisms have relevance to the factors that affect homeless people's HSU.

Thirdly, research could also be conducted with groups who are not homeless, but are known not to use health services (e.g. in Ireland it is known drug users and ethnic minorities have different HSU behaviors) and see if the external barrier, deterrent and promoter, and internalized cognitive / emotional inhibitors and promoters matrix can be used to explain their HSU patterns.

Fourthly, research could be done in other medical and non-medical areas (e.g. education) to see if the concept of conversations of exclusion is identified in other settings.

Fifthly, the extent of barriers to treatment created by the level of violence and aggression described by participants as existing in the vicinity of large addiction treatment centres. If such barriers are confirmed it would raise questions as to either how to manage such aggression/violence or whether smaller centres would reduce such barriers.

Lastly, further research should be conducted to identify if 'going into withdrawals' due to lack of substitute provision is a barrier to obtaining healthcare for homeless people and substance misusers waiting in hospital emergency departments or inpatient admission.

### **Limitations of the Research.**

There are a number of limitations to this study. First and foremost, this research was conducted at a limited number of sites with homeless people in Dublin at a particular time. As such results, need to be cautiously interpreted in their application to the whole homeless population in Dublin. Furthermore, the results can only truly be interpreted as being valid for that population and are subject to the vagaries of trends changing with time.

Secondly, I, as the researcher, was an insider in the field prior to commencing the research and as a doctor attended many of the homeless people encountered when in the research role. The most significant disadvantage in this regard was that participants may not have interacted freely with me having known me in my prior role as a doctor. This may have limited their interactions and the opinions proffered. Taking into account the high social status accorded to doctors, this may have prevented participants interacting in a natural manner with me.

However, it also offered advantages. It enabled me to gain introductions to the varying research sites and to particular individuals with whom I had previously formed relationships. I was also enabled to use my prior knowledge to explore particular themes; using previously good relationships to enable me to explore more sensitive issues; and lastly, by using previously bad relationships (due to negative doctor patient interactions) to explore those same interactions from a different perspective. Lastly, this position afforded me alternate perspectives on the interactions between health staff and participants as I had tacit knowledge of health staffs and perspectives on healthcare in relation to homeless people. This was due both to being a member of the medical community and to being a programme director of 48 GP trainees who regularly recounted their interactions between health services and homeless people.

A significant limitation was that I, as researcher, had founded and worked in a number of specialised services for homeless people. This had significant potential to bias my opinions of specialised services which were viewed in a favourable light within the research.

Lastly, I was the sole coder and interpreter of the data collected during the research.

While I adopted a reflexive approach to question the findings in the light of these limitations, readers of the thesis need to be still aware of their possible effects on the findings.

## **Summary**

This thesis has explored the HSU behaviour of homeless people and identified a pattern of HSU behaviour previously identified in other studies. It identified a number of factors that influenced that HSU behaviour, some of which were new to the literature. It offered a different conceptual framework of external barriers, deterrents and promoters along with internalised inhibitors and promoters for analysing those same factors identified as influencing HSU. It adopted a critical realist approach and suggested a number of generative mechanisms for the HSU behaviour of homeless people as well as a critical realist explanatory model for the HSU behaviour of homeless people. This study has a number of limitations that affect its potential to be transferred and generalised. It offers a number of possible policy and practice interventions that could address some of the generative mechanisms that affect the HSU behaviour of homeless people detrimentally.

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## APPENDICES:

### Appendix I: Semi Structured Interview Schedule.

#### Topics / Questions to be explored.

The following is a list of topics and questions to be explored as part of the Semi Structured Interview. The purpose is not to ask all of these questions but to ask the ones that seem most relevant. Further relevant topics / questions may arise during the course of the research that may be added to the schedule.

<b>Topics:</b>	<b>Possible Questions (if applicable).</b>
<b>Exploring Illness Behaviour</b>	What sort of illnesses/sicknesses do you have / get?
	When you get sick how do you manage it. (e.g. do you do nothing, do you take medicines, do you go to health service?)
	What are the influences that affect how you manage your health? (e.g. friends/family opinions, no time, other priorities)
	What makes you decide to attend a health service? What makes you decide not to attend a health service?
	If you attend late on for illnesses why do you not attend earlier?
	What sort of things prevent or delay you in getting your health problems treated?
	What health services would you tend to go to? (GP Nurse A/E Hospital.)
	Could any other type of health service have dealt with this condition? If so which ones? If so, why did you not attend those services?
<b>Effect of Homelessness on Usage of Health Service Usage?</b>	How does your homelessness affect you ability to take care of your health.
	How does your homelessness affect your ability to access healthcare?
	How does your homelessness affect your usage of other health services?
<b>General Practice</b>	Have you had any difficulties obtaining a GP and getting to see a GP? If so what are they?
	Have you ever had any problems when seeking anxiety or sleeping medication and how did it affect your experience of attending a doctor?
	How could GP's make their service more acceptable?
	Do you have a medical card? If not, why not?
<b>Hospitals</b>	Do you ever use A/E? If so what do you use it for?
	Have you ever had any problems when seeking anxiety or sleeping medication and how did it affect your experience of attending a hospital?
	Have you ever been an inpatient – what was your experience?
	Have you ever used OPD – if so what was your experience?
	How could GP's make their service more acceptable?
<b>Accessibility of Health Services</b>	What health services do you find easy to use and why?
	What health services do you find difficult to use and why?

## Appendix II a

**Table: Demographics, Substance Misuse, Mental Health and Blood borne Infectious status of Interview Participants.**

ID	Sex	Age	Hx IV Drug Use	Hx of Benzo Abuse	Hx Alcohol Misuse	Hx of Methadone Treatment	Hx Mental Ill Health	Hx HIV	Hx Hep C	Hx of being in care	Housing
P-1	M	37	Y		Y	Y	Y				Rough Sleeper
P-2	M	38	Y		Y	Y	Y		Y		Rough Sleeper
P-3	F	35	Y	Y		Y	Y				Hostel
P-4	M	49	Y	Y	Y	Y	Y		Y		Hostel
P-5	F	40	Y	Y	Y	Y	Y				Hostel
P-6	M	35	Y	Y		Y	Y		Y		Hostel
P-7	F	33		Y							Hostel
P-8	M	36	Y	Y					Y		Hostel
P-9	F	21	Y			Y					Hostel
P-10	F	24	Y	Y					Y		Hostel
P-11	M	32	Y	Y		Y	Y	Y			Hostel
P-12	F	34	Y	Y	Y		Y		Y		Hostel
P-13	M	31	Y	Y		Y					Hostel
P-14	M	39	Y	Y		Y	Y	Y	Y		Rough Sleeper
P-15	M	31	Y	Y		Y	Y				Hostel
P-16	F	31	Y	Y					Y		Hostel
P-17	F	44	Y	Y			Y		Y		Hostel
P-18	M	30	Y	Y							Hostel
P-19	M	31	Y	Y					Y		Hostel
P-20	F	45					Y				Hostel
P-21	M	37	Y	Y		Y			Y		Hostel
P-22	F	50	Y	Y					Y		Hostel
P-23	M	63				Y				Y	Hostel
P-24	M& F	31 & 6	Y & Y	Y & Y			Y & Y		Y & Y		Hostel
P-25	M	48				Y	Y	Y	Y		Hostel
P-26	F	31	Y	Y					Y		Hostel
P-27	M	30	Y	Y			Y				Hostel
P-28	M	33	Y	Y					Y		Hostel
P-29	M										Hostel
P-30	F	30	Y	Y			Y		Y		Hostel
P-31	M	42	Y	Y					Y		Hostel
P-32	M	37					Y		Y		Hostel
P-33	M	45	Y	Y		Y					Hostel

P-34	M	26	Y	Y	Y						Hostel
P-35	M	39	Y	Y					Y		Hostel
P-36	F& M	20 & 29	Y & Y	Y & Y		Y					Hostel
P-37	M	40	Y								Hostel
P-38	F	25	Y	Y			Y		Y		Hostel
P-39	F& M		Y	Y	Y		Y	Y	Y		Hostel
P-40	M	23					Y				Hostel
P-41	F	28	Y	Y			Y			Y	Hostel
P-42	M	37	Y	Y	Y		Y			Y	Rough Sleeper
P-43	M	23	Y	Y	Y	Y	Y			Y	Hostel
P-44	M	59			Y		Y			Y	Rough Sleeper
P-45	M	58	Y	Y	Y	Y		Y			Hostel
P-46	F	48	Y	Y	N	Y		Y			Hostel
P-47	M	53	Y	Y	N	Y		Y			Hostel

## Appendix IIb

<b>Table: Ethnographic and Focus Group Participants Demographics, Accommodation Status and Brief Description.</b>					
<b>ID</b>	<b>Sex</b>	<b>Age</b>	<b>Location Encountered</b>	<b>Description</b>	<b>Housing</b>
McVP-A	M	30-50	McVerry Trust Drop-In Regular Attendee	Quiet reserved man whose children in care. Active Drug User. On methadone.	Hostel
McVP-B	F	30-50	McVerry Trust Drop-In Occasional Attendee	Very sociable. Ex Drug Use.	Hostel
McVP-C	M	30-50	McVerry Trust Drop-In Occasional Attendee	Dropped in but rarely stayed long in Drop-In. Active Drug User.	Hostel
McVP-D	M	30-50	McVerry Trust Drop-In Regular Attendee	Ex IVDU with active benzo addiction. Very charming but could become angry easily. Partner of McVP-O	Hostel
McVP-E	M	20-30	McVerry Trust Drop-In	Sociable. Active Drug User.	Hostel
McVP-F	F	20-30	McVerry Trust Drop-In	Sociable young woman.	Hostel
McVP-G			McVerry Trust Drop-In		Hostel
McVP-H	M	30-50	McVerry Trust Drop-In	Active Drug User. Looked underweight and unwell.	Hostel
McVP-I	M		McVerry Trust Drop-In	Active Drug User. Looked underweight and unwell.	Hostel
McVP-J	M	20-30	McVerry Trust Drop-In	Active Drug User.	Hostel

McVP-K	F	30--50	McVerry Trust Drop-In	Past drug user with HIV infection.	Hostel
McVP-L	M	30-50	McVerry Trust Drop-In	Person with active schizophrenia and active drug user. Abnormal unusual behaviours. Though he was loner accepted by everyone in drop-in	Hostel
McVP-M	F	30-50	McVerry Trust Drop-In	Past drug user with HIV infection.	Hostel
McVP-N	F	30-50	McVerry Trust Drop-In	Large, outgoing woman who worked in Trust. Had a lot of authority amongst attendees. Ex Drug User.	Hostel
McVP-O	F	30-50		Ex IVDU with active benzo addiction. Wanted to obtain access to children. Partner of McvP-D	Hostel
RSTP-A	F	20-30	With Rough Sleeper Team	Partner of RSTP-B. Living in squat. Active IVDU. Had IVDU induced Cardiac infections. Underweight. History of domestic violence.	Rough Sleeper
RSTP-B	M	20-30	With Rough Sleeper Team	Partner of RSTP-A. Living in squat. Active IVDU Underweight. History of domestic violence.	Rough Sleeper
RSTP-C	M	20-30	With Rough Sleeper Team	Active occasional IVDU. Came to Dublin to get methadone. Ex rough sleeper now in hostel.	Hostel
RSTP-D	M	20-30	With Rough Sleeper Team	Young man I met huddled on ground. Brother had recently died.	Hostel / Rough Sleeper
RSTP-E	M	50-70	With Rough Sleeper Team	Long-term history of rough sleeping and alcoholism. Longterm non engaged with services. Very affable.	Rough Sleeping
RSTP-F	F	20-30	With Rough Sleeper Team	Active Drug User. Juvenile rheumatoid arthritis. Quite disabled. Very difficult to engage. Could become quite abusive. Developed TB.	Rough Sleeping
RSTP-G	F	20-30	With Rough Sleeper Team	Active Drug User who came to Dublin from country. Socially isolated.	Hostel
RSTP-H	M	20-30	With Rough Sleeper Team	Active Drug User. Came to Dublin to get methadone. Difficult to engage.	Hostel
RSTP-I	M	30-50	With Rough Sleeper Team	Active Drug User. Injecting in to groin. On anti coagulant due to previous DVT.	Hostel
RSTP-J	M	20-30	With Rough Sleeper Team	Active Drug User. Injecting into groin. On anti coagulant due to previous DVT. Recently evicted from hostel.	Rough Sleeper
RSTP-K	M	20-30	With Rough Sleeper Team	Active Drug User. Came to Dublin to	Rough Sleeper

				get methadone. Sleeps rough as scared of hostels	
RSTP-L	M	20-30	With Rough Sleeper Team	Active Drug User. Came to Dublin to get methadone. Sleeps rough as scared of hostels	Rough Sleeper
RSTP-M	M	50-70	With Rough Sleeper Team	Elderly man who stayed all day and slept in same doorway – would shout at any one who approached him.	Rough Sleeper
RSTP-N	M	30-50	With Rough Sleeper Team	Chronic Alcoholic. Died due to head injury.	Rough Sleeper
RSTP-O	F	30-50	With Rough Sleeper Team	Chronic Alcoholic. History of recent coughing up blood and weight loss due to probable TB.	Rough Sleeper
RSTP-P	M	20-30	With Rough Sleeper Team	Active Drug User. Stayed in hostel with doctor who provided methadone but was too busy to visit him.	Hostel
RSTP-Q	M	20-30	With Rough Sleeper Team	Deaf since birth. Had minimal language. Could sign language. Would get frustrated and angry easily.	Rough Sleeper
RSTP-R	M	20-30	With Rough Sleeper Team	Once off brief encounter queuing for outreach bus..	Hostel
RSTP-S	M	20-30	With Rough Sleeper Team	Once off brief encounter.	Hostel
RSTP-T	M	30-50	With Rough Sleeper Team	Once off brief encounter queuing for outreach bus.	Hostel
RSTP-U	M	30-50	With Rough Sleeper Team	IVDU. Partner of RSTP-V	Hostel
RSTP-V	F	30-50	With Rough Sleeper Team	IVDU who was on methadone. Had ben diagnosed with Hepatitis C but defaulted from treatment. Partner of RSTP-U	Hostel
RSTP-W	M	30-50	With Rough Sleeper Team	Moldovan man who had come to Ireland to work. Stayed in hostel mainly populated with non Irish.	Hostel
RSTP-X	F	30-50	With Rough Sleeper Team	Woman with anorexia who would stay most of day in her hostel room. Very reticent to allow keyworkers or health professionals to see her.	Hostel
RSTP-Y	M	50-70	With Rough Sleeper Team	Man with schizophrenia – long-term rough sleeper. Ex lawyer. Very witty and intelligent. Behaviourally very challenging e.g. when in hostel smeared faeces on walls.	Rough Sleeper.
RSTP-Z	M	30-50	With Rough Sleeper Team	Had ended up homeless after release from prison. Jailed for violent sexual	Rough Sleeper

				assault. Lived in fear of assault due to this history.	
RSTP-1A	M	30-50	With Rough Sleeper Team	Brief encounter. Man who could not read text.	Hostel
RSTP-1B	M	30-50	With Rough Sleeper Team	Polish man who had been working in Ireland but became unemployed and started drinking heavily. Stayed in hostel mainly populated with non Irish.	Rough Sleeper
RSTP-1C	F	20-30	With Rough Sleeper Team	Active drug user. Injecting into groins. Came to Dublin seeking methadone.	Rough Sleeper
RSTP-1D	M		With Rough Sleeper Team	Eastern European who had come over to work in building trade. Became unemployed. Stayed in hostel mainly populated with non Irish.	Rough Sleeper
RSTP-1E	M		With Rough Sleeper Team	Active drug user. Had been sent to Amicus in Drug Treatment Centre where receives low dose supervised methadone. Seen as form of punishment.	Rough Sleeper.
RSTP-1F	M	20-30	With Rough Sleeper Team	Once off encounter. Was severely drunk and trying to gain access to hostel. Had been barred due to previous behaviour.	Hostel
RSTP-1G	M	30-50	With Rough Sleeper Team	Man with history of mental health. Had been in university. Very aggressive on first interaction. History of heavy drinking.	Hostel
CapP-A	M	30-50	Capuchin Food Hall	Ex IVDU who was on methadone. Left apartment after being assaulted by neighbour. Partner of CapP-B	Rough Sleeping
CapP-B	F	30-50	Capuchin Food Hall	Ex IVDU who was on methadone. Left apartment after being assaulted by neighbour. Partner of CapP-B	Rough Sleeping
CapP-C	F	20-30	Capuchin Food Hall	Ex drug user who had just lost her apartment and had to move in with male stranger who had a spare bed.	Couch surfing
CapP-D	F	30-50	Capuchin Food Hall	Woman (non Irish) who kept to herself in food hall. Socially isolated. Originally from country. Lived in very religious hostel.	Hostel
CapP-E	F	30-50	Capuchin Food Hall	Very talkative Nth American woman who had son and lived in very	

				religious hostel.	
CapP-F	M	30-50	Capuchin Food Hall	IVDU – chaotic. Just diagnosed with hepatitis C. Recently out of prison.	Hostel
CapP-G	F	20-30	Capuchin Food Hall	Ex IVDU – on methadone. Used benzo tablets. Very affable and well known in food hall.	Hostel
CapP-H	F	30-50	Capuchin Food Hall	IVDU – very affable. Fears doctors so defaulted from Hepatitis C Treatment	Hostel
CapP-I	M	30-50	Capuchin Food Hall	Ex IVDU – has been on methadone since 90's. Previous diagnosis of Hepatitis C but defaulted from treatment	Hostel
CapP-J	F	30-50	Capuchin Food Hall	IVDU and frequent rough sleeper. Life was very chaotic with drugs not in control. Did not follow up on Rheumatoid arthritis diagnosis due to chaos.	Hostel
CapP-K	M	30-50	Capuchin Food Hall	Chronic alcoholic and smoker. Would go on binges when he would rough sleep. Afraid of authority including doctors	Hostel
CapP-L	M	20-30	Capuchin Food Hall	IVDU who was on methadone and recently got off the street.	Hostel
CapP-M	M	50-70	Capuchin Food Hall	Older man who has history of alcohol misuse. On aspirin for stroke.	Hostel
CapP-N	M	30-50	Capuchin Food Hall	Had history of homelessness and now in UK where he lives in hostel. Home for Xmas.	Hostel
CapP-O	F	20-30	Capuchin Food Hall	IVDU. Looks underweight. Could become very angry quickly.	Hostel
CapP-P	M	20-30	Capuchin Food Hall	Once off encounter with man who came into food hall with open wound on cheek and refused to go to ED.	Hostel
CapP-Q	M	20-30	Capuchin Food Hall	IVDU who had been beaten up outside methadone treatment centre so defaulted	Hostel
CapP-R	M	30-50	Capuchin Food Hall	Ex IVDU who had been on methadone. Quiet and reserved but knew many of people in Capuchin centre.	Hostel
CapP-S	M	20-30	Capuchin Food Hall	Distrustful and difficult to engage. Became angry when he heard I was doctor and explained why he hated	Unknown



				doctors.	
CapP-T	F	20-30	Capuchin Food Hall	Young IVDU who lived with partner. Children were in care. Very frail and thin.	Hostel
CapP-U	M	50-70	Capuchin Food Hall	Man who had been homeless but had his own flat for a number of years but liked to come to Capuchin for the food and the social life.	Own flat.
CapP-V	M	50-70	Capuchin Food Hall	Man with mental health problems who attended psychiatry services. Hard to engage.	Hostel
FG1P-A	M	30-50	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-B	M	30-50	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-C	F	20-30	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-D	F	20-30	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-E	M	30-50	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-F	F	30-50	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG1P-G	M	30-50	Focus Group 1 Homeless Participant	Resident in Drug/ Alcohol Stabilization Unit	Stabilization Unit
FG2P-A	M	50-70	Focus Group 2 Homeless Participant	Ex IVDU who hung round drop in centres still. Lot of medical issues.	Hostel
FG2P-B	M	30-50	Focus Group 2 Homeless Participant	Ex IVDU who used occasionally. Very stable and calming presence	Hostel
FG2P-C	M	30-50	Focus Group 2 Homeless Participant	IVDU. Chaotic in his usage. Very intelligent and articulate.	Hostel
FG2P-D	M	30-50	Focus Group 2 Homeless Participant	IVDU who came across as innocent. Had history of medical problems	Hostel
FG2P-E	F	30-50	Focus Group 2 Homeless Participant	Ex IVDU. Very steady and calm in her manner. Raised own children even when on drugs. Partner of FG2P-F	Homeless Accommodation Apartment
FG2P-F	M	30-50	Focus Group 2 Homeless Participant	Ex IVDU. Had history of being in prison. Partner of FG2P-E	Homeless Accommodation Apartment
FG2P-G	M	30-50	Focus Group 2 Homeless Participant	IVDU. Quiet reserved man who made occasional contributions	Unknown
FG2P-H	M	30-50	Focus Group 2 Homeless Participant	IVDU. Had to leave group early.	Unknown

FG1D-A			Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG1D-B	F	30-50	Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG1D-C	M	30-50	Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG1D-D	F	20-30	Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG1D-E	F	20-30	Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG1D-F	F	20-30	Focus Group 1 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG2D-W	F	20-30	Focus Group 2 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG2D-X	F	30-50	Focus Group 2 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG2D-Z	M	30-50	Focus Group 2 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG2D-Y	F	20-30	Focus Group 2 Doctor Participant	Senior House Officer in Hospital on GP training scheme	
FG2D-W	F	20-30	Focus Group 2 Doctor Participant	Senior House Officer in Hospital on GP training scheme	

### **Appendix III: Personal Safety.**

Violence and aggression is pervasive in homelessness.[1] Researchers working in the field of homelessness need to be constantly aware of the potential that they might face aggression or violence during their fieldwork. On one occasion I encountered a man who I had previously refused to give benzodiazepines in my work as a doctor. He became very aggressive in that he raised his voice and started jabbing his finger towards me and talking aggressively. At that moment I felt afraid and was aware of a threat to my personal safety.

There are several strategies available to a researcher to manage their safety. These strategies can be grouped under the headings of planning; safety rules; and interpersonal safety skills.

**Planning for Safety:** In planning, a researcher can ensure that the sites they choose have adequate safety provisions.[2] There are no hard and fast rules as to which sites are safe and which are not but there are a number of factors the researcher can take into account when assessing the sites. Firstly, the researcher can assess what is the potential for being left alone without access to a staff member who could help defuse a situation or protect the researcher. The factors the researcher needs to take into account are staff/client ratios; the layout of the building; the availability of portable or fixed (i.e. in the rooms where the researcher will be working) alarms. If the researcher is working on the street they should take into account whether they have potential people whom they can trust near at hand; are they working in a public environment where help is always nearby; and how well do they know and trust the participant they are working with. This may seem counter-intuitive to a researcher who wishes to set up a trusting relationship with the participant. The trick is to be able to balance developing a relationship while being sensible about not exposing oneself to unnecessary risk.

Planning also includes setting up interview spaces that are safe. It is best if there are staff nearby who can come to the rescue if the researcher seeks help. The researchers chair should be between the door and interviewee. The researcher should identify if there are alarm buttons in the room. Lastly, it is best if the space is open and relaxing as claustrophobic rooms can promote irritability in respondents. At the sites I attended there was always plenty of key workers around and I always had the option of being accompanied by a keyworker if I so desired. In my work with the RST I always made my

first contact with participants in the presence of an outreach worker. It was only when I got to know clients well that I would go and meet them alone. I did not have the option of a personal alarm at any of the sites. However, in the McVerry Trust Drop-In and in the Mater Hospital, there were alarm buttons in any room I used to interview clients alone. I also set up the room so as to position myself between the door and interviewee. I had no such room available at the Capuchin Centre or with the RST and would conduct interviews in public.

**Safety Rules:** It is wise to adopt a number of safety rules when conducting research. These rules are not meant to be rigid but if the researcher intends breaking them they should think carefully as to why and what other safety precautions they can take instead.

- Do not allow yourself be alone with someone whom you do not know. When you do decide to interview a client alone, ensure you have already developed a relationship with them and have thought through the safety pros and cons of such action.
- If you are unsure of a person or situation ask the staff's advice before approaching the situation. In the McVerry drop-in I met a homeless man whom I found threatening in manner but whom I wanted to interview. I asked the keyworkers who told me that as long as I was straight up with him he would not get aggressive. So I told him straight up what I was doing and he agreed to an interview and presented no threat.
- Ask keyworkers at each site about how they handle safety. For example, in my work with the RST, I asked keyworkers how they would approach a homeless person on the street that they did not know. They told me of their strategy of how to make initial approaches to homeless people which was to make an approach by standing a few feet away from the person (so as not to invade their personal space) and then to introduce themselves and ask the homeless person would they like some support and list the things they could do to help that person. They would then gauge the person's response. If (s)he wanted help they would come closer but still maintain a foot or two distance. They would often go to the level of the person e.g. hunker down if the person was sitting down on the pavement. If (s)he absolutely refused they would ask permission to come back another day. In my experience this rarely happened. If the person was uncertain they would tell him/her that they would give them time to think and they would stand a good distance away from the person but still in sight of the person. After a time (which varied depending on the instinct of the keyworker) they would return and ask again while maintaining a few feet distance. I

adopted this approach when seeking to interview rough sleepers and found it very effective and also safe.

- If you are unsure as to whether meeting a participant is safe or not, arrange to interview them somewhere that is reasonably public e.g. in a cafe or open public space where people pass or congregate.
- If you do decide to interview someone alone e.g. in a room in a hostel or at a public site tell someone else of your plan. If it is in a hostel or service tell a staff member. If it is in a public place tell someone you know. Have their number on speed dial in case you need to call them. If you are particularly unsure you can ask them to check in on you by phone at a particular time. You can also arrange to ring them once you are finished so they know the interview is over.

**Interpersonal Safety Skills:** There are a number of interpersonal skills I have learnt to manage aggression/violence in my own work which I found were equally useful in the research process;

- When engaging potential participants in conversation ensue you tell them early on of your role as a researcher. This prevents possible feelings of betrayal if you reveal your role after they have confided in you. Be wary of asking for favours (e.g. an interview) too early. In the drop-in and food hall where people attended regularly It is worthwhile meeting the participant a few times prior to asking for an interview. This allows you gauge how much you can trust them or not. In my experience I often did not need to ask for a formal interview as conversations allowed me explore my area of interest which would arise spontaneously.
- Watch out for signals of increased tension which could be gleaned from body language and tone of the person. Also monitor one's own emotions. Feelings of unease or tension can be important signals that dictate how much the researcher engages or removes themselves from the conversation.
- On the rare occasion where aggression does arise there are recognised techniques for managing aggression. These include, showing only intermittent eye contact; speaking calmly and with an even tone; listening to what the person says, trying to identify what they are angry about and responding to such where possible (including the use of the phrase 'I am sorry if I caused offence'). On occasions where there the researcher feels under threat they can use the technique of naming their fear and the behaviours inducing

that fear. This involves the researcher using phrases such as ‘Sorry but I feel afraid and the reason I feel afraid is you are raising your voice and leaning towards me. On occasion one may need to repeat this a few occasions (the broken record technique). On the occasion where I did feel threatened in the McVerry drop-in (as described above) I did say that I was sorry if I had caused offence but that I felt nervous due to him jabbing his finger towards me and raising his voice. This served to stop him jabbing his finger at me though his voice stayed raised. However, another homeless person who was beside him, having heard what I had said, told him to leave me alone and relax.

I would say that by far the most effective elements in maintaining my safety was using my interpersonal skills as these prevent a situation becoming aggressive or violent. My strong sense is that even if I had been with a keyworker or had an alarm with me if a person I was engaging with became aggressive or violence neither would have been of significant help if the person wanted to harm me.

I also noted that those keyworkers whom I perceived to have the best relationships with their clients displayed many of these key skills described above. Their pace of developing relationships was always slow and confidently tentative. I use the term confidently tentative as their approach was always respectful of body space and careful not to interfere with whatever the homeless person was doing, while also being confident in their approach i.e. they exuded quiet calm rather than fear. An example of this was when I went out with the needle exchange programme and we approached a ‘shooting gallery’ (i.e. a squat, corner, basement where they inject drugs) and we saw a man jump over the rails of the gallery, with what seemed like a needle in his hand. We did not approach until he had used the heroin. Then the outreach worker called down to him and said we were distributing clean needles and would he be interested in talking to us. He then came up and offered him a cigarette. They chatted and then gave him some clean needles and gave him harm reduction advice. I told him during the conversation I was a researcher and asked would he mind me chatting to him. He agreed and I talked to him while the outreach workers stood about 20 yards away chatting to each other.

1. Coudray C. Violence within the lives of Homeless People. School of Clinical Psychology. 2010, University of Southampton.
2. Craig, GA, Cordren, Thonton P. Safety in Social Research, in Social Research Update. 2000. University of Surrey

**NOTICE RE RESEARCH TAKING  
PLACE HERE IN THE (CAPUCHIN  
CENTRE / DUBLIN SIMON / PETER  
MC VERRY TRUST).**

My name is Austin O Carroll. I am a researcher working with the Mountjoy Street Fam Pract and the University of Bath. I am conducting research to understand what do homeless people do when they feel sick or unwell. The questions I will be seeking to answer include:

- When and why do homeless people decide to consult?
- Why do they decide to not consult when ill?
- How do they decide who to consult?
- How do past experiences of consulting health services influence their present behaviour?

As part of this research on certain nights I will be sitting in the waiting area here where I hope to talk to homeless people so as to find out why they have come to visit the hospital. I will only ask questions of those people who identify themselves as being homeless to me and who give me consent to ask questions.

Everything you say is treated confidentially. It will not be possible for you to be identified as your name will not be used. You may leave or refuse to answer any question at any point.

Signed: \_\_\_\_\_ (Austin O Carroll)

## **NOTICE RE RESEARCH TAKING PLACE IN THE WAITING ROOM OF THE EMERGENCY DEPARTMENT MATER HOSPITAL**

My name is Austin O Carroll. I am a researcher working with the Mountjoy Street Fam Pract (53 Mountjoy St, Dublin 7 (01) 8303325) and the University of Bath. I am conducting research to understand what do homeless people do when they feel sick or unwell. The questions I will be seeking to answer include:

- When and why do homeless people decide to consult?
- Why do they decide to not consult when ill?
- How do they decide who to consult?
- How do past experiences of consulting health services influence their present behaviour?

As part of this research on certain nights I will be sitting in the Emergency Department waiting room where I hope to talk to homeless people so as to find out why they have come to visit the hospital. I will only ask questions of those people who identify themselves as being homeless to me and who give me consent to ask questions.

Everything you say is treated confidentially. It will not be possible for you to be identified from the questionnaires as your name will not be used. You may leave or refuse to answer any question at any point.

Signed: \_\_\_\_\_ (Austin O Carroll)



## **Appendix Va. Information Sheet for Semi Structured Interviews**

Austin O Carroll 53 Mountjoy St, D.7. (01) 8303325.School for Health. Univesity of Bath.

*Austin O Carroll  
Doctoral Research Student  
Professional Doctorate in Health  
School for Health  
Bath University  
Bath*

### **Re: Consulting Behaviour of Homeless People Information Sheet**

Dear Participant,

I am a researcher working with the Mountjoy Street Fam Pract and the University of Bath. I am conducting research to understand what do homeless people do when they feel sick or unwell. The questions I will be seeking to answer include:

- When and why do homeless people decide to consult?
- Why do they decide to not consult when ill?
- How do they decide who to consult?
- How do past experiences of consulting health services influence their present behaviour?

I am inviting you to take part in this study by answering questions. Taking part is voluntary and your decision.

Everything you say is treated confidentially. It will not be possible for you to be identified from the questionnaires as your name will not be used. You may leave or refuse to answer any question at any point.

The questions will take no longer than 45 minutes.

I hope this research will contribute to better health services for homeless people in Dublin.

Results from this research may be published in a report or in journals in order to raise awareness about how best to design health services for homeless people.

**Signed:**

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Austin O Carroll

## **Appendix Vb: Information Sheet for Focus Group Participants.**

Austin O Carroll 53 Mountjoy St, D.7. (01) 8303325.School for Health. Univesity of Bath.

*Austin O Carroll  
Doctoral Research Student  
Professional Doctorate in Health  
School for Health  
Bath University  
Bath*

### **Re: Consulting Behaviour of Homeless People Information Sheet**

Dear Participant,

I am a researcher working with the Mountjoy Street Fam Pract and the University of Bath. I am conducting research to understand what do homeless people do when they feel sick or unwell. The questions I will be seeking to answer include:

- When and why do homeless people decide to attend a health service?
- Why do they decide to not attend a health service when ill?
- How do they decide who to attend a health service?
- How do past experiences of attending health services influence their present behaviour?

I am inviting you to take part in this study by joining a focus group where we will discuss the issues described above. We will meet with five to six other homeless people and I will put certain questions for the group to discuss. You can partake in the group as little or as much as you like. You can choose not to reveal any information that you feel may be too personal. Taking part is voluntary and your decision.

Everything you say is treated confidentially. It will not be possible for you to be identified as your name will not be used. You may leave or refuse to answer any question at any point.

The group will take no longer than 2 hours.

I hope this research will contribute to better health services for homeless people in Dublin.

Results from this research may be published in a report or in journals in order to raise awareness about how best to design health services for homeless people.

**Signed:**

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Austin O Carroll

## **Appendix VI: Consent form.**

Austin O Carroll 53 Mountjoy St, D.7. (01) 8303325.School for Health. Univesity of Bath.

**To consult or not to consult! An ethnographic exploration conducted in Dublin, of the factors that affect homeless person's health seeking behaviour.**

**Please tick the appropriate answer.**

*I confirm that I have read and understood the Patient Information Leaflet dated \_\_\_\_\_ attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.   ☐Yes   ☐No*

*I understand that this study has been granted ethical approval by the ethics committees of Bath University, the Irish College of General Practitioners and the Mater Hospital.*

*☐Yes   ☐No*

*I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason, and without this decision affecting my future treatment or medical care.   ☐Yes   ☐No*

*I understand that my identity will remain confidential at all times..   ☐Yes   ☐No*

*I have been given a copy of the Information Leaflet and this Consent form for my records.   ☐Yes   ☐No*

### **FUTURE USE OF ANONYMOUS DATA:**

*I agree to participate in the study and agree that I will not restrict the use to which the results of this study may be put. I give my approval that unidentifiable data concerning my person may be stored or electronically processed for the purpose of scientific research and may be used in related or other studies in the future..   ☐Yes   ☐No*

*Participant Name: \_\_\_\_\_*

*Participant Signature: \_\_\_\_\_*

*Date: \_\_\_\_\_*

***To be completed by the Principal Investigator or his nominee.***

*I the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a manner that he/she could understand. I have explained the risks*

*involved, the experimental nature of the treatment, as well as the possible benefits and have invited him/her to ask questions on any aspect of the study that concerned them.*

*Name:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*3 copies to be made: 1 for patient, 1 for PI*

## Appendix VII: Screenshots of NVivo Coding.

Homeless January 2014 Ver 11.mpg - NVivo

Navigation View: Find, Quick Coding, Workspace

Look for: Search In: Third Level Coding Find Now Clear Advanced Find

Third Level Coding (4)

Name	Sources	References	Created On	Created By	Modified On	Modified By
Background Nodes	78	1378	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Exploratory Model for HSU	81	2404	01/02/2014 21:19	AOC	01/02/2014 20:04	AOC
External Barrier - Administrative Barriers	42	118	27/09/2014 16:33	AOC	01/02/2014 21:55	AOC
Features of Health Services & Professionals & homeless people that promote or deter HSU	76	960	01/02/2014 21:19	AOC	01/02/2014 20:03	AOC
HSU Behaviour Category	54	239	01/02/2014 21:19	AOC	27/01/2014 00:09	AOC
HSU Behaviour - Defaulting	17	24	01/02/2014 21:19	AOC	01/02/2014 23:41	AOC
HSU Behaviour - Delayed Presentation	36	62	01/02/2014 21:19	AOC	01/02/2014 18:23	AOC
HSU Behaviour - ED	15	34	01/02/2014 23:36	AOC	01/02/2014 23:36	AOC
HSU Behaviour - Hospital Inpatient	6	7	01/02/2014 23:39	AOC	01/02/2014 23:39	AOC
HSU Behaviour - Hospital OPD	16	42	01/02/2014 23:37	AOC	01/02/2014 23:40	AOC
HSU Behaviour - Methadone Treatment Centre	6	8	01/02/2014 23:40	AOC	01/02/2014 23:40	AOC
HSU Behaviour - Poor Compliance with medicine	10	30	01/02/2014 21:19	AOC	01/02/2014 23:38	AOC
HSU Behaviour - Psychiatry	2	2	01/02/2014 23:41	AOC	04/02/2014 22:19	AOC
Individual Health Services Promoters, Barriers, Deterrents and Inhibitors of HSU	69	730	01/02/2014 21:19	AOC	01/02/2014 20:06	AOC

AOC: 741 Items

Homeless January 2014 Ver 11.mpg - NVivo

Navigation View: Find, Quick Coding, Workspace

Look for: Search In: Third Level Coding Find Now Clear Advanced Find

Third Level Coding (4)

Name	Sources	References	Created On	Created By	Modified On	Modified By
Background Nodes	78	1378	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Exploratory Model for HSU	81	2404	01/02/2014 21:19	AOC	01/02/2014 20:04	AOC
Environment Effect on HSU Category	18	39	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
External HSU Barriers and Deterrents	70	429	01/02/2014 21:19	AOC	27/01/2014 00:09	AOC
External HSU Promoters	42	154	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Interactions that Negatively Impact on HSU	48	256	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Interactions that Positively Impact on HSU	13	20	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Internal Personal Features that Inhibit HSU	8	11	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Internal Personal Features that promote HSU	2	2	01/02/2014 21:19	AOC	01/02/2014 23:54	AOC
Internalised Inhibitors to HSU	61	412	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Internalised Promoters of HSU	45	171	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Realities that affect HSU	75	857	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Self Management of Health affects HSU	13	53	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
External Barrier - Administrative Barriers	42	118	27/09/2014 16:33	AOC	01/02/2014 21:55	AOC
Features of Health Services & Professionals & homeless people that promote or deter HSU	76	960	01/02/2014 21:19	AOC	01/02/2014 20:03	AOC
HSU Behaviour Category	53	209	01/02/2014 21:19	AOC	27/01/2014 00:09	AOC
Individual Health Services Promoters, Barriers, Deterrents and Inhibitors of HSU	69	730	01/02/2014 21:19	AOC	01/02/2014 20:06	AOC

AOC: 741 Items

Homeless January 2014 Ver 11.mpg - NVivo

Navigation View: Find, Quick Coding, Workspace

Look for: Search In: Third Level Coding Find Now Clear Advanced Find

Third Level Coding (4)

Name	Sources	References	Created On	Created By	Modified On	Modified By
Cognitive Barriers	43	215	01/02/2014 21:19	AOC	29/01/2014 22:10	AOC
HSU Inhibitor - Deferral to Future Cognitions	6	11	01/02/2014 21:19	AOC	29/01/2014 04:35	AOC
HSU Inhibitor - Denial Cognitions	14	34	01/02/2014 21:19	AOC	29/01/2014 04:35	AOC
HSU Inhibitor - Fatalistic Cognitions	18	47	01/02/2014 21:19	AOC	29/01/2014 04:35	AOC
HSU Inhibitor - It's harder to come off methadone than heroin Cognition	1	1	01/02/2014 21:19	AOC	29/01/2014 04:38	AOC
HSU Inhibitor - Presumption of Discrimination Cognition	10	26	01/02/2014 21:19	AOC	29/01/2014 04:36	AOC
HSU Inhibitor - Presumption of Poor Treatment due to Poor Past Personal or Reported Experiences	17	47	01/02/2014 21:19	AOC	29/01/2014 04:36	AOC
HSU Inhibitor - Self Blame Cognitions	12	37	01/02/2014 21:19	AOC	29/01/2014 04:35	AOC
HSU Inhibitor - Seriousness of Condition Cognitions	7	11	01/02/2014 21:19	AOC	31/01/2014 04:48	AOC
Emotional Barriers	48	195	01/02/2014 21:19	AOC	29/12/2013 19:10	AOC
HSU Inhibitor - Emotion - Anger	8	14	01/02/2014 22:54	AOC	01/02/2014 23:00	AOC
HSU Inhibitor - Emotion - Embarrassment	10	26	01/02/2014 21:19	AOC	01/02/2014 15:44	AOC
HSU Inhibitor - Emotion - Fear or Anxiety	35	96	01/02/2014 23:00	AOC	01/02/2014 23:04	AOC
HSU Inhibitor - Emotion - Hopelessness	18	36	01/02/2014 21:19	AOC	01/02/2014 23:08	AOC
HSU Inhibitor - Emotion - Lack of fear of serious disease due to familiarity	2	3	01/02/2014 21:19	AOC	01/02/2014 19:23	AOC
HSU Inhibitor - Feeling worthless - low self esteem	8	20	01/02/2014 23:06	AOC	01/02/2014 23:06	AOC
HSU Inhibitor - Did not think to go for treatment	1	2	01/02/2014 21:19	AOC	29/01/2014 22:59	AOC
Internalised Promoters of HSU	45	171	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Realities that affect HSU	75	857	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
Self Management of Health affects HSU	13	53	01/02/2014 21:19	AOC	29/01/2014 23:05	AOC
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HSU Behaviour Category	53	209	01/02/2014 21:19	AOC	27/01/2014 00:09	AOC

AOC: 741 Items

